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ABSTRACT

The goal of this first comprehensive report on adolescent health in Alaska is to stimulate interest, activity, and support for improved health among teenagers (ages 10-19). This plan was developed as a tool for use by governments, organizations, and communities. The plan seeks to provide information on the scope and nature of adolescent health problems; to identify and clarify trends in the health status of adolescents; to recognize and emphasize that social and health problems are significantly interrelated; to motivate families, schools, social service organizations, health care providers, the media, business, the state legislature, and adolescents to take action to improve the health status of adolescents; to outline the general components of successful adolescent health programs based on review of current literature; and to recommend specific strategies to improve adolescent health care. The plan emphasizes the general themes of an integrated approach to health, prevention, and early intervention; the importance of family; and economic issues. Following the executive summary, the plan is organized into six sections: (1) basic assumptions about adolescent health; (2) the status of adolescent health in Alaska (problems related to substance abuse, sexual activity, mental health, physical health, violence and crime, unintentional injuries, and school achievement); (3) framework for designing adolescent health programs through collaboration; (4) recommendations for the family, neighborhoods and community, and public policies; (5) a list of services consisting of eight directories and referral sources; and (6) a toolbox section of checklists, questionnaires, and data collection guides for assessment and planning. Five appendices list Committee biographies, risk and protective factors, Health Alaskans 2000 objectives, cost savings of prevention, and a summary of adolescent health public hearings. Contains references, figures, tables, glossary, and an extensive bibliography. (SAS)

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A PLAN FOR THE FUTURE

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Alaska Adolescents: A Plan for the Future was developed in two parts. Sections I, II, and III were released in 1994; Sections IV, V, and VI were completed in 1995.

The Adolescent Health Plan was produced by the Department of Health and Social Services, Division of Public Health, Section of Maternal, Child, and Family Health, at a cost of $11.49 per copy in Anchorage, Alaska.

Contents

Acknowledgments i

Alaska Adolescent Health Advisory Committee iii

Introduction 1
  Overview of the Adolescent Health Advisory Committee 2
  Use of the Plan 2

Executive Summary 3

Section 1: Basic Assumptions About Adolescent Health

  Stages of Healthy Adolescent Development 7
  The Concept of Youth Development 10
  Risk and Protective Factors 11
  Alaska's Youth at Risk: Who are they? 13
  References 14

Section II - The Status of Adolescent Health in Alaska

  Data Considerations 17
  Data Contributors 21
  Socioeconomic Status of Adolescents 23
  Indicators for Assessing Adolescent Health
    Substance Use 29
    Sexual Activity 37
    Mental Health 47
    Violence and Crime 55
    Unintentional Injuries 63
    Physical Health 69
    School Achievement 75
  Research and Data Needs 81

Section III: Framework for Designing Adolescent Health Programs

  The Economics of Prevention 87
  Obstacles to Overcome 87
  Critical Elements of Successful Programs 89
  A Possible Model: Collaboration at the System Level 92
  Alternatives to System-Level Collaboration:
  Other Interagency Partnerships 95
  Summary 96
  References 97

Section IV: Recommendations

Core Recommendations 99
Family 107
Neighborhoods and Communities 114
Schools 119
Local Agencies and Community Organizations 124
Policy Makers and State Program Directors 134
Legislators 138
References 143

Section V: Services

Resources to Identify Services for Children, Adolescents, and their Families .. 145

Section VI: Toolbox for Communities

Critical Elements of Successful Programs 151
Strategy and Collaboration Questionnaires 155
Program Approaches That Work 159
Community Planning Process 169
Local Health Assessment 175

Appendices:

A: Alaska Adolescent Health Advisory Committee Biographies
B: Risk and Protective Factors
C: Healthy Alaskans 2000 Objectives
D: Cost Savings of Prevention
E: Adolescent Health Public Hearings

Glossary

Bibliography

Figures

Figure 1 Adolescent Population Engaging in Problem Behavior 13
Figure 2.1 Alaska Adolescent Population by Ethnicity 24
Figure 2.2 Public Assistance Provided to Adolescents 25
Figure 2.3 Monthly Earnings by Education Level 26
Figure 2.4 Alaska Teen Substance Use - 1988 30
Figure 2.5 Primary Treatment Services Alaska Youth 18 and Under 32
Figure 2.6 Percent of Students Reporting Having Had Sexual Intercourse 38
Figure 2.7 Reported Contraceptive Use by Alaska Teens 39
Figure 2.8 Teen Pregnancy Outcomes 40
Figure 2.9 Comparative Teen Birth Rates 41
Figure 2.10 Adolescent Psychiatric Disorders 48
Figure 2.11 Teen Suicide Rate 49
Figure 2.12 Frequency of Drug/Alcohol Use Among Youth Suicide Attempters 50
Figure 2.13 FY92 Reports of Harm by Allegation 56
Figure 2.14 Pregnant Teens with a History of Being Abused 57
Figure 2.15 Percent of Alaska Teens Having Been Abused 58
Figure 2.16 FY92 Alaska Youth Probation Referrals by Category 59
Figure 2.17 FY89-FY92 Youth Probation Referrals 59
Figure 2.18 FY92 Juvenile Detention by Ethnicity 61
Figure 2.19 Fatality-Injury Pyramid 64
Figure 2.20 Safety Belt Use by Alaska Teens 66
Figure 2.21 Alaska Teens Who Ride With A Drinking Driver 66
Figure 2.22 Alaska Drowning Victims by Ethnicity 67
Figure 2.23 Alaska Teens "Somewhat" Overweight and Obese 71
Figure 2.24 Preventable Behavioral Risk Factors Leading to Chronic Diseases 72
Figure 2.25 School Enrollment by Urban/Rural Districts 76
Figure 2.26 Alaska High School Dropouts 78

Tables

Table 1 Stages of Healthy Adolescent Development 9
Table 2.1 Regional Profile: Runaways by Gender 27
Table 2.2 Peak Age of Substance Experimentation by Alaska Teens 30
Table 2.3 Past Month Use - Cigarettes, Alcohol, Marijuana 31
Table 2.4 Chronic Alcohol Use and Chronic Smoking 31
Table 2.5 Past Month Use - Cocaine, Inhalants, Hallucinogens 31
Table 2.6 Percent of Alcohol-Related Youth Fatalities 31
Table 2.7 Percent of Students Reporting Having Had Sexual Intercourse 38
Table 2.8 Reasons for Not Using Contraception 39
Table 2.9 Comparative Teen Birth Rates 41
Table 2.10 Number of Alaska Teen Suicides by Ethnicity 49
Table 2.11 Adolescents Receiving Mental Health Services by Provider 51
Table 2.12 Medicaid Reimbursed Mental Health Services FY92 51
Table 2.13 FY92 Final Outcome of 8,466 C.P.S. Investigations 57
Table 2.14 FY89-FY92 Youth Probation Referrals 59
Table 2.15 FY92 Police Reports of Criminal Activity by Alaska Youth 60
Table 2.16 Unintentional Injury Deaths Alaskans (10-19) 64
Table 2.17 Causes of Adolescent Injury Deaths, Alaska 1980 - 1989 65
Table 2.18 Percent of Alcohol-Related Youth Fatalities 66
Table 2.19 Common Eating Disorders and Attitudes Among Alaska Adolescents 70
Table 2.20 Comparative Alaska/U.S. Adolescent Body Weights by Gender 71
Table 2.21 Health Conditions Limiting School Activities of Alaska Adolescents .. 73
Table 2.22 High School SAT Scores 77
Table 2.23 ITBS 8th Grade Scores 77
Table 2.24 Relationship of Self-Reported School Performance to Selected Risk Factors 77
Table 2.25 Alaska Annual "Early Leaver" Rate by Ethnicity 78
Table 2.26 Educational Attainment and Employment Status 79

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9

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Introduction

In recent years, teen pregnancy has been the subject of two state task forces, in-depth research, and many local efforts. Senate Bill 170, passed in 1991, created a position at the Department of Health and Social Services to develop a statewide plan for action. Recognizing that teen pregnancy does not happen in isolation of other adolescent risk behavior, the Division of Public Health has examined this issue in the broader context of adolescent health.

To gain a comprehensive view of adolescents, an advisory committee representing a variety of perspectives was established. Membership includes representatives from the areas of education, public health, labor, law enforcement, adolescent medicine, native health, the business community, alcohol and drug prevention, mental health, family planning, and runaway and homeless services. In addition, teenagers from rural and urban settings lent their practical experience to this committee. See Appendix A for a short biography of each member.

The mission statement of the Alaska Adolescent Health Advisory Committee reads:

> *The Alaska Adolescent Health Advisory Committee is a diverse group of Alaskans united in the commitment to well-being and healthy lifestyles for Alaskan adolescents, as individuals and within the context of family and community. We look at known "roots" to adolescent health problems and recommend approaches for improvement through community coordination and collaboration. We seek to preserve the rights of all Alaskan adolescents to grow and develop in an environment of physical, intellectual, social, emotional and spiritual well-being.*

During its first years, the committee has devoted itself to developing a statewide adolescent health plan. As a starting point, a needs assessment was conducted to find out the status of adolescent health in Alaska. More than one hundred reports and studies were analyzed. Instead of focusing on specific behaviors (delinquency, teen pregnancy, school drop out, substance use, etc.) the committee believed that greater emphasis must be placed on their common risk and protective factors. Recommendations were developed based on the current health status of Alaska's adolescents, testimony from public hearings, committee members own expertise, and what research has shown to be effective.

Use of the Plan

This plan is written primarily for those community members (parents, religious leaders, teachers, health care providers, counselors, youth workers or youth-serving organizations) interested in serving the needs of adolescents. It is intended to help community members in planning and evaluating programs and services targeting adolescents. Additionally, the plan is intended to serve local and state elected officials in their efforts to provide a sound public policy base for enhancing adolescent health.

The appendices, glossary and bibliography serve as additional resources for users of the plan.

Overview of the Flan

Section I: Basic Assumptions About Adolescent Health

This section begins by defining adolescence and presenting an overview of the psychosocial developmental stages of adolescence. The concept of "youth development", authored by Karen Pittman, is introduced. Risk and protective factors are described and an analysis of the overlapping problem behaviors illustrates those teens most at risk.

Section II: The Status of Adolescent Health in Alaska

The incidence and prevalence rates of major adolescent problem behaviors are described. This section is divided into seven areas: substance use, sexual activity, mental health, violence and crime, unintentional injuries, physical health, and school achievement. Over 100 primary sources were reviewed and analyzed to condense this information into one source.

Section III: Framework for Designing Adolescent Health Programs

The obstacles to effective adolescent health programs and the elements necessary for program success are presented. An important key to improving programs and services for children, adolescents and their families is greater collaboration. Types of collaboration and system level changes needed to support collaboration are explained.

Section IV: Recommendations

Specific recommendations to enhance the health and well-being of Alaska's youth are provided for the family, community (neighborhoods, schools, and local agencies), and policy level (policy makers and state program directors, legislators).

Section V: Services

This section lists several directories and referral sources with current information on programs and services for children, youth, and their families.

Section VI: Toolbox

To help communities implement the recommendations, specific "tools" (checklists, guidelines, background information, and questionnaires) are provided.

"... for the first time in our history American adolescents are regressing in health and social well-being ..."

- Joy Dryfoos

Executive Summary

The future of Alaska's adolescents is in our hands and our future is in theirs. In response, the Alaska Adolescent Health Advisory Committee is pleased to present ***Alaska's Adolescents: A Plan for the Future***, its first report on adolescent health in Alaska. Our goal is to stimulate interest, activity and support for improved health among Alaska's teenagers. This plan was developed as a tool for use by governments, organizations and communities. It specifically seeks to:

- provide information on the scope and nature of adolescent health problems;
- identify and clarify trends in the health status of adolescents;
- recognize and emphasize that social and health problems are significantly interrelated;
- motivate families, schools, social service organizations, health care providers, the media, business, the legislature and adolescents themselves to take action to improve the health status of teens in Alaska by the year 2000;
- outline the general components of successful adolescent health programs based on reviews of the current literature; and
- recommend specific strategies to improve adolescent health in Alaska.

This plan was developed by the Alaska Adolescent Health Advisory Committee. The committee serves as an advisory and advocacy council to the State of Alaska on adolescent health matters.

Alaska's Adolescents: A Plan for the Future is organized in six sections:

Section I: Basic Assumptions About Adolescent Health
The psychosocial developmental stages of adolescence, the youth development model, and risk and resiliency factors are reviewed.

Section II: The Status of Adolescent Health in Alaska
Data on the seven major adolescent health problems is presented: substance use, sexual activity, mental health, violence and crime, unintentional injuries, physical health, and school achievement.

Section III: Framework for Designing Adolescent Health Programs
The obstacles to effective adolescent health programs and the elements necessary for program success are presented. An important key to improving programs and services for children, adolescents, and their families is greater collaboration. Types of collaboration and system level changes needed to support collaboration are explained.

Section IV: Recommendations
Adolescent health is determined mainly by the behaviors adolescents choose to engage in. The ability of youth to make wise decisions about their behavior—and their ability to act on their decisions—is greatly influenced by their **family**, the **community**, and **public policies**. Thus, the recommendations are organized around these three distinct entities. "Family" includes the variety of arrangements of people living together and nuturing children and adolescents. "Community" contains more specific recommendations for neighborhoods, local agencies, and schools. "Policy" level recommendations are geared toward state agencies and legislators.

All of the specific recommendations offered for the separate entities are based on five core recommendations, the ideas that the Committee recognized to be the "heart" of the solutions. These were featured so prominently in the research about successful programs, and were so integrally related to our understanding of adolescent health, that they quickly emerged as the essence of the change required.

Core Recommendations:

- Provide for local decision making
- Collaborate
- Meet the needs of young children (ages 0-6)
- Focus on risk and protective factors rather than specific behaviors (such as pregnancy or substance abuse)
- Follow research about what works

Section V: Services
A list of directories and referral sources with current information on programs and services for children, youth and families is presented. The listed resources regularly update their directories to keep up with changes in focus, location, service populations, etc.

Section VI: Toolbox
A collection of specific concepts or processes referred to in the recommendation section is offered. These tools are provided as a means of bringing the recommendations a step closer to actual implementation at the community level.

Included in this section are:

- "Critical Elements of Successful Programs" checklist
- Strategy and collaboration questionnaires
- Program approaches that work
- Community planning process steps
- Local health assessment guidelines

General Themes

Throughout this plan several general themes are emphasized. These concepts include: an integrated approach to health; prevention and early intervention; the importance of family; and economic issues. Each concept is briefly described below.

Integrated Approach to Health and Well-being

Recently published national reports—*Adolescents at Risk, Code Blue: Uniting for Healthier Youth, Adolescent Health* (vol. 1-3), and *Fateful Choices*—conclude that, for the first time in our history, American adolescents are regressing in health and social well-being. Drug abuse, sexually transmitted diseases, pregnancy, homelessness, delinquency, crime, and unintentional and violent deaths have increased. Healthy dietary and exercise habits, routine health care, and education levels have decreased. These social and health problems are significantly interrelated and their associated diseases occur together. We hope to focus attention on the interrelatedness of adolescent health problems and offer more effective strategies for health promotion and disease prevention. Most current strategies are short-term, inconsistent with the developmental and environmental contexts of adolescence, and are too specific to be useful across the broad range of adolescent health behavior. Models exist for comprehensively addressing adolescent health needs. These models are discussed in the plan as alternatives to our current approach.

Prevention/Early Intervention

The 12-year-old does not become a "problem child" overnight. Adolescent health problems develop over time. Signs of impending trouble are usually seen in early childhood. Systems for early identification of "children at risk" must be established before problems develop. Once these problems become fully manifest, they are difficult, costly, and often nearly impossible to remedy. Nurturing health promoting behavior must begin in childhood. If we are to shift the balance in a troubled child's life, we must start early. Exposure to risk factors and stressful events must be decreased. At the same time, the available positive factors in the lives of vulnerable children must be increased.

Importance of "Family"

Adolescents require nurturing, encouragement, guidance, protection, negotiated limits, and consistent expression of values via communication and positive role-modeling. Traditionally, families provided these factors, but with the social changes in our communities now many teens grow up without this support. Measures can be designed to strengthen troubled families. If these needs are still not met within the family, then society must provide alternatives. Every teen needs an adult who will listen, guide and support. Schools and community resources will be increasingly called upon to provide an expanded support system for many children.

Economic Issues

The costs of teen pregnancy, violence, mental illness, alcohol/tobacco/other drug use, and dropping out of school are considerable. These costs can be measured in both hard currency and the social costs to families and communities. Where known, dollar figures are provided throughout the plan. Costs for prevention are likely to be only a fraction of the sums spent in remediation attempts once problems have occurred. The most efficient expenditure of funds is in prevention.

Data Considerations

Adequate data is essential to solving adolescent health problems. While many sources were used in developing this plan, the need for broader and more accurate data in many areas still exists. In particular, greater emphasis should be given to evaluation research. Research is difficult to fund with scarce resources, but evaluating the effectiveness of programs is crucial to ensuring that funds are used efficiently and that benefits outweigh costs.

Summary

Greater emphasis must be placed on prevention of adolescent health problems and the promotion of healthy lifestyles. This will require changes in the method by which health is "promoted" and health care is delivered to adolescents in Alaska. No one sector can accomplish this alone. A partnership for collaboration must be formed among the key players including teens, families, primary health care providers, the media, public agencies, schools, community groups, the Legislature, and private business. This effort requires leadership, collaboration, commitment, and cooperation to meet the challenge of improved adolescent well-being. Let us now get down to the hard work of creating a better system for the future.

> ***"Prevention/Early Intervention***
> ***is an attempt to shift the balance***
> ***from vulnerability to resilience,***
> ***either by decreasing exposure***
> ***to risk factors and stressful life events,***
> ***or by increasing the number of***
> ***available protective factors***
> ***in the lives of vulnerable children."***
>
> *- E. Werner, 1990*

Basic Assumptions About Adolescent Health

An adolescent's health and well-being exist within the context of his/her family, community and culture. The committee recognizes that prevention of adolescent health problems and the development of healthy life skills begins in early childhood. The Governor's Interim Commission on Children and Youth 1988 publication *Our Greatest Natural Resource* describes many early intervention strategies that pave the way to subsequent adolescent health.

Adolescent Development

For the purposes of this report, adolescence has been defined as 10-19 years old. It is a period of profound biological, emotional, intellectual, and social transformation unmatched by any other period in life, except perhaps infancy. In modern North American society, adolescence seems to begin before puberty as preadolescents adopt the dress and mannerisms of teens. It appears to continue well beyond the teen years as many young adults remain dependent upon their families because of continued school enrollment, unemployment or limited earnings.[1,10]

The transformation from puberty to adulthood is characterized by tremendous variability from individual to individual. The physical changes are dramatic. Emotions can fluctuate between elation and depression. Intellectual capacity deepens and adolescents gradually become capable of higher order thinking and reasoning. The expectations of family members, teachers, friends, and society sometimes lead to confusion about issues of independence, conformity, and responsibility.[1, 10]

The process of moving from childhood to adulthood may be divided into three general stages of adolescence: early (10-13), middle (14-16), and late (17 until adulthood.) During this transformation several major physical, emotional, and mental developmental "tasks" have been identified:

- development of self-identity and a sense of social responsibility;
- acceptance of body image;
- determination of sexual identity and role;
- development of a personal value system and ethics;
- transition from dependence on family to independence;
- development of mature personal relationships, including sexual relationships; and
- identification of possible career goals and acquiring the skills necessary for greater economic independence. [11]

By progressing through the physical, mental, and emotional developmental tasks, a normal, healthy young adult emerges. It is important to remember, however, that there is great variability in how individuals develop. Table 1 gives a more detailed review of these developmental tasks.

Part of normal adolescent development is risk-taking behavior (see Table 1). Some adolescent health specialists believe experimentation with a variety of behavior is necessary for the healthy development of the young person.[5, 6] According to Hochhauser,

> The goal of prevention should not be to eliminate all risky behavior from life; instead it should be to help adolescents and young adults learn about the inappropriate and appropriate risks. There is a life after adolescence and individuals who have grown up in a riskless environment may not be able to cope with the challenges of adulthood, for example, the workplace or parenthood, without having had some risk-taking experiences.[6]

Table 1

STAGES OF HEALTHY ADOLESCENT DEVELOPMENT[2,3,6]

Age Range	**EARLY ADOLESCENCE**	**MID-ADOLESCENCE**	**LATE ADOLESCENCE**
	Begins between ages 11 and 13 and merges with mid-adolescence at 14 to 15 years	*Begins around 14 to 15 years and blends into late adolescence about age 17*	*Approximately 17 to early adulthood. (Dependent on cultural, economic and educational factors*
CHARACTERISTICS:			
Physical Growth	Puberty: Rapid growth period Secondary sexual characteristics appear	Secondary sexual characteristics advanced 95% adult height reached	Physical maturity and reproductive growth leveling off and ending
Intellectual/ Cognition	Concrete thought dominates "here and now" Cause-effect relationships under developed Stronger "self" than "social" awareness	Growth in abstract thought Reverts to concrete thought under stress Cause-effect relationships better understood Very self-absorbed	Abstract thought established Future oriented; able to understand, plan and pursue long range goals Philosophical and idealistic
Psycho-social Body Image	Preoccupation with rapid body changes Anxieties about physical changes Uncertainty with body image "Am I normal" concern	Growth stabilizes New body image established Concern with attractiveness - dating Fantasy & idealism in exploration of future	Comfortable with body image Intellectual and functional identity established Arriving at concept of self as an adult
TASK AREAS:			
Identity	Increased need for privacy Risk-taking behavior begins Begins developing identity changes Lack of impulse control Challenges authority Increased fantasy world	Sense of invisibility and all-powerfulness Risk-taking behavior increases Experimentation: sex, drugs, friends, jobs Vocational goals more realistic	Realistic vocational goals pursued Sexual identity established Personal limitations & mortality realized Able to compromise and set limits Religious and moral values more refined
Independence	Family becomes less important than friends Defining independence-dependence Wide mood swings	Independence-dependence conflicts dominate Questioning parental authority Exploring family values Struggle for emancipation	Emancipation Beginning of self-sufficiency and care Parental advice and values re-evaluated Adult-to-adult relationships emerge
Peer Group	Intense friendship with same sex Cliques develop; affiliation sought to counter instability Constantly compares self with peers Initiates contact with opposite sex, in groups	Strong peer allegiances; fad behavior Conformity with peer values; peers help to define behavioral code Peer identification affirms self-image	Peer group less important and has less influence on decisions/values More time spent in individual relationships
Sexuality	Emerging sexual feelings Self-exploration and evaluation Limited dating Sexual experimentation (usually not intercourse)	Multiple relationships Heightened sexual activity Testing: ability to attract sexual partner Masculine and feminine roles explored "Love object" the most important thing in the world	Forms stable relationships Capable of give-and-take in relationships Less focus on "self" more "other-oriented" Begins thinking of marriage, family Commitment in relationships, replaces earlier romanticism

Unfortunately many behavioral risks that adolescents may take during this time, such as those with substances and sexual experiences, can lead to serious health or life threatening consequences.

Improvements in health and nutrition over the last few generations have resulted in the earlier onset of puberty. Meanwhile the world of work has grown far more complex than it was a century ago. The education process to prepare our young people for the adult world has become longer and more complex. Adolescents who achieve biological maturity at age twelve may have six to ten more years of education and socialization ahead of them before they will be competent to handle the adult world of work and relationships. [12]

The Concept of Youth Development

Karen Johnson Pittman refers to the holistic growth process as "youth development." She describes it as the ongoing natural process of having one's basic needs met and acquiring life skills. Functioning well and feeling connected to a family entity and community are two critical elements in the process toward maturity and self-fulfillment. All sectors of society have a responsibility for the well-being and development of our youth. Pittman explains:

> The definition of youth development considers the reduction of risky behavior and existing problems as important, but it asserts that competence and strong connections to the larger society are essential in preparing youth for the challenges of adulthood. It is not enough to develop strategies to prevent dangerous things . . . We must be equally adamant about stating goals we wish young people to achieve.[9]

In addition, this concept values all adolescents by recognizing their inherent value and the contributions they can make. The seven basic needs and five areas of competency necessary for achieving healthy adulthood, according to the youth development model, are described below.

Critical Components of Youth Development[9]

Basic Needs

Young people have basic needs critical to survival and healthy development. They include:

- safety and structure;
- closeness within relationships;
- belonging and membership;
- a sense of competence and mastery;
- self-worth and an ability to contribute to the larger community;
- self-awareness; and
- independence and control over one's life.

Competencies/Life Skills

To succeed as adults, youth must acquire healthy attitudes, behavior, and skills in at least five areas:

Health

Maintenance of a good health status and evidence of knowledge, attitudes, and behavior that will assure future well-being (for example: exercise, good nutrition, and effective contraceptive practices, including abstinence).

Personal/Social

Acquisition of intrapersonal skills (understanding emotions and practicing of self-discipline) and interpersonal skills (working with others: developing and sustaining friendships through cooperation, empathy, and negotiation and by developing judgment skills and a coping system).

Knowledge, Reasoning, and Creativity

Acquiring a broad base of knowledge and an ability to appreciate and demonstrate creative expression. Possessing good oral, written, and problem-solving skills. Having an ability to learn and an interest in lifelong learning and achieving.

Vocational

Knowledge of realistic life options and the steps necessary to make choices. Understanding the value and purpose of family, work, and leisure and the necessary preparation of each.

Citizenship

Understanding of their nation's, their community's, and their racial, ethnic, or cultural groups' history and values. Desire to be ethical and to be involved in efforts that contribute to the broader good.

To the extent that these needs can be met and competencies nurtured, adolescents have a tremendous capacity for self-fulfillment and contributing to society. This model of youth development represents an ideal, however, and it's prudent to examine the real experience of today's youth. To do so, a review of the literature regarding risk and resiliency (protective) factors is offered.

Risk and Protective Factors Affecting Adolescent Health

Adolescent health may be defined, for purposes of this report, as the ability of an adolescent to move through the normal developmental process toward maturity. The developmental process can be disrupted by risk factors within the individual, family, or community. The extent of these disruptions defines a young person as "at risk." Whatever level of risk the adolescent may experience s/he still has the potential to become a mature and self-fulfilling adult. Research has found that adolescent behavior is profoundly affected by risk factors and resiliency (protective) factors within the adolescent's life.[7, 8, 13-18]

What is the importance of risk and resiliency factors when designing adolescent health interventions? The more we can reduce the risk factors and increase the protective factors present in children's lives, the more likely our children will develop into healthy competent young adults.

Risk Factors

"Risk" is a concept used to predict the chance a behavior will occur. Risk factors may be intrinsic, within the individual; or extrinsic, within the family, community, or environment.[8, 14, 16-18]

As medical researchers have found risk factors for heart disease (high fat diets, smoking, and lack of exercise), researchers have also identified a set of risk factors for adolescent problem behavior. The more risk factors for heart disease present, the greater the likelihood a person will suffer a heart attack. The same is true for other health behavior. The greater the number of risk factors in an adolescent's life, the more likely the problem behavior will occur (school failure, drug/alcohol use, promiscuous sex/teen pregnancy, delinquency).[8, 14-17]

Risk factors do not cause the problem behavior. They are indicators of the probability that a behavior will occur.

Risk Factors Affecting Adolescent Problem Behavior
(Substance Abuse, Teenage Pregnancy, Delinquency, and School Failure)

- Poor attachment to family, inattentive parenting, family management problems[7, 23]
- Antisocial behaviors (conduct disorders) in grades K-3.[7, 23]
- Doing poorly in school in grades 4-6.[7, 23]
- Onset of the problem behavior at an early age (age varies with behavior.)[7,23]
- Low resistance to friends who engage in problem behavior[7, 23]
- Poverty[7]
- History of abuse (physical or sexual)[8, 21, 22]

Minority status and low socioeconomic status have been shown to compound the risk factors in many cases.[7, 8]

Protective Factors

"Protective Factors" (resiliency) are those traits within the individual or characteristics of the family, community, or environment that appear to alter or even reverse the effects of life stressors and risk factors.

Extensive research has identified factors that enable children from high risk environments to develop into healthy competent young adults.[8, 13, 14, 16, 17] The greater the number of personal and environmental protective factors the less likely the adolescent will engage in life-compromising behavior.

A review of adolescent health literature, particularly concerning substance abuse, delinquency, school drop out, and sexual activity reveals many common risk factors.[7, 13, 15, 18] Research shows that engaging in one problem behavior increases the likelihood of engaging in other problem behaviors.[7]

Protective Factors Affecting Adolescent Problem Behavior

- One good parent bond or other stable, caring adult. High, clear, and reasonable expectations of behavior.[7, 13]

- Supportive school atmosphere characterized by a respectful staff, discipline policies that respect student's dignity, and services available to help troubled students.[13]

- Opportunities for meaningful contribution to family, school, or community.[13]

- Delay of the problem behavior at an older age (age varies with behavior).[7]

- Having a resilient temperament and a positive social orientation.[14,23]

(See Appendix B for a more detailed description of the risk and protective factors for the individual, family, school and community.)

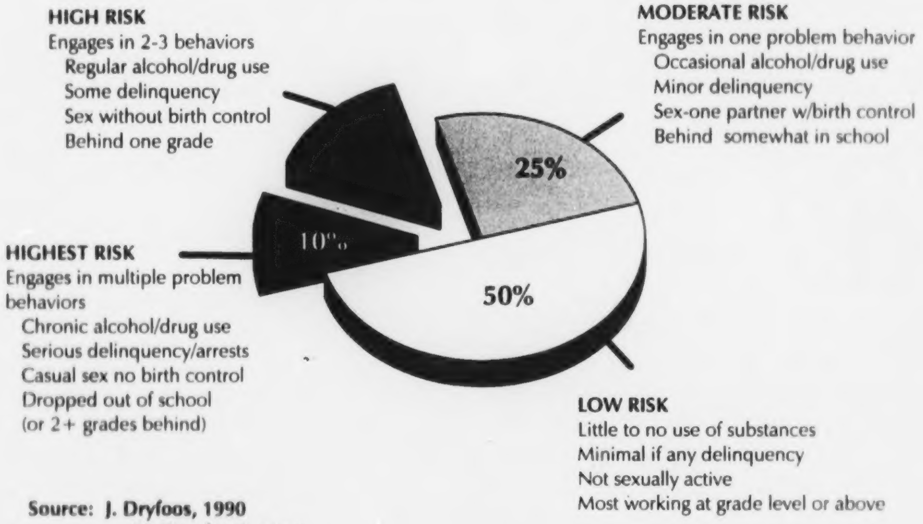
Alaska's Youth at Risk: Who are They?

An estimated one in four adolescents are involved in serious problem behaviors.[7,20] Based on a national risk behavior model[7] and 1990 state census data,[19] we can infer that more than 20,000 of Alaska's adolescents are in need of intensive care for psychological or physical health reasons.

This estimate further suggests that another 20,000 Alaskan adolescents engage in a single problem behavior, but they are otherwise healthy and functional. The remaining portion (about half) of our adolescents are not currently engaged in problem behavior, and are moving along toward adulthood without major difficulties at home or at school.

Figure 1

Teens Engaged in Problem Behavior



Source: J. Dryfoos, 1990
(National estimates)

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The Status of Adolescent Health in Alaska

This section documents the findings of the needs assessment conducted by the Adolescent Health Advisory Committee and the Division of Public Health. The socioeconomic status and seven major health status indicators were examined:

- socioeconomic status 23
- substance use 29
- sexual activity 37
- mental health 47
- violence and crime 55
- unintentional injuries 63
- physical health 69
- school achievement 75

Over 100 primary sources have been reviewed, consolidated, and presented. A team of reviewers, including an epidemiologist and data analyst, examined each data source to determine its credibility and importance for inclusion in this assessment. In addition, the entire section was reviewed by the Section of Epidemiology. A discussion of the major data considerations used by the review team is offered below.

Recognizing the need for improved data, an outline of adolescent health data needs is provided at the end of this section. A detailed explanation of unfamiliar terminology is provided in the glossary.

Numerous agencies and individuals served as invaluable resources for the data presented in this report. A listing of all data contributors is provided at the end of this section.

Data Considerations

Many studies on adolescent health indicators have been cited in this report. Compiling and comparing statistics from different sources has inherent problems, in part, because of inconsistent definitions of:

- adolescent age;
- health behavior; and/or
- the time period studied.

In addition, data sources often lacked a well-documented methodology, making it difficult to evaluate the quality and ability to generalize the results to other populations. Some sources inadequately presented their study results making it extremely difficult to understand what the figures represented.

Research design factors limited the use or at least the applicability of some data. For example, a survey may have been done with a small number of individuals who were not randomly selected, thereby limiting the ability to generalize to the larger population. Another concern is the inherent problem of comparing data from study to study over time. Observed changes or trends may not reflect true changes in the population, but differences in the methods used to calculate change.

An epidemiologist and data analyst examined each data source. Sometimes the reviewers elected to use data sources with methodological problems because of the lack of data available on a given topic from a credible source. The use of data sources in this plan should not be interpreted as scientific approval by the reviewers or the Adolescent Health Advisory Committee. However, all sources used in this plan were deemed to be the best presentation of subject information currently available.

A summary of the methodology is provided here for three data sources referenced extensively in this report: "The State of Adolescent Health in Alaska, 1990," "Drug Taking Behavior Among Alaska Youth," and data from the Bureau of Vital Statistics, including the report, "Causes of Death in Alaska 1950, 1980-1989."

The State of Adolescent Health in Alaska

This study, often referred to as the Adolescent Health Survey, represents a comprehensive self-report health survey of over 5,000 7th-12th grade students in nineteen school districts statewide in 1989. The primary limitation of this survey is that it did not include students in Anchorage and Fairbanks. As a result, this survey may not represent the health status of urban adolescents in Alaska. Also, since 25% of teenagers do not graduate from high school, the survey does not include that portion of the population at highest risk for health compromising behavior. Finally, the use of self-reported data has some inherent limitations. Certain adolescent populations may over- or under-report specific behavior based on what is perceived as the most socially desirable choice.

Drug Taking Behavior Among Alaska Youth - 1988 A Follow-up Study

This self-report survey was administered to 7th-12th grade students in ten school districts: Anchorage, Barrow, Bethel, Fairbanks, Juneau, Kotzebue, Nome, Sitka, Cordova, and Seward. In some school districts all students were surveyed and in other school districts a random sample of students was surveyed. A total of 4,129 students participated in the survey, of whom 28% (1,147) resided in Anchorage and 20% (836) resided in Fairbanks. Drawing inferences to the entire population of adolescents from this survey is problematic. For example, only 28% of the survey respondents resided in Anchorage, yet Anchorage accounts for almost 40% of the adolescent population. If adolescent problem behavior varies by region, the data presented could be misleading. Another problem with the report is that most data were presented as the prevalence of drug-taking behavior among "ever users" of that drug and not among all survey respondents. The data presented in this report reflects our derived estimates on the prevalence of drug-taking behavior among all survey respondents. Deriving these estimates was problematic because of inconsistencies in the numbers presented throughout the report.

Bureau of Vital Statistics

The Bureau of Vital Statistics within the Alaska Division of Public Health compiles data on births, deaths, marriages, divorces, and adoptions. The information is published in annual reports and periodic newsletters. Three year averages are often used for the presentation of health indicators with relatively small numbers. By grouping several years of data, the rates become more "stable" and can be more readily compared over time. Suicides and injury-related deaths are reported as three year averages. It is important for the public to understand that the Bureau is continuously modifying their statistics as new data becomes available.

The report, "Causes of Death in Alaska 1950, 1980-1989" was compiled from an exhaustive review of each death certificate on file in the Bureau of Vital Statistics. Alaskan residents who died out of state were not included in the statistical analyses and rate calculations. The cause of death was determined by a physician and not a nosologist (someone who classifies diseases).

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Adolescent Population

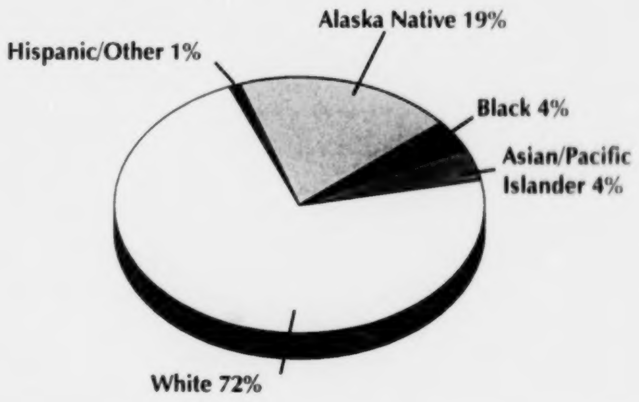
- Adolescents (ages 10-19) make up 15% of Alaska's total population.[9]
- In 1990 the adolescent population was 80,330.[9]

Younger teens (10-14 years old)	43,179
Older teens (15-19 years old)	37,151

- Residence of population for all ages:
  - 70% Urban (2,500 and over)
  - 30% Rural[10]
- Over one-third of adolescents do not live in a two-parent household.[13]
- 53% of all students (K-12) are enrolled within the Anchorage and Fairbanks North Star Borough School Districts.[10]

Figure 2.1

1990 Alaska Adolescent Population by Etnicity[12]



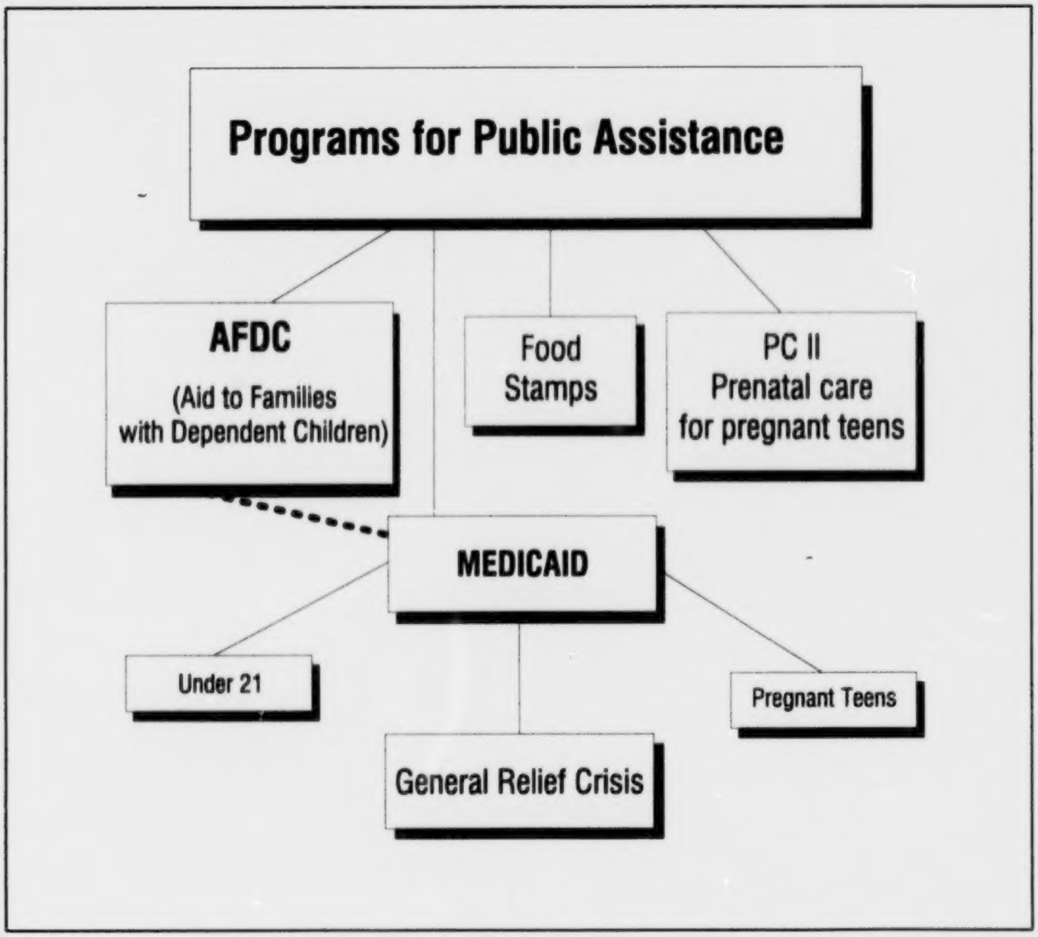
Poverty

- 14% of adolescents 10-19 live below the Alaska poverty level ($15,843 annual household income for a family of four, 1989).[5]
- Medicaid Services were provided to 5,474 teens (15-20), at a cost of $17.3 million in FY92.[8]

Public Assistance

Services to low income adolescents are provided through a variety of channels. Additionally, many family planning, mental health, and substance abuse services are provided on a sliding fee scale.

Figure 2.2
Public Assistance Provided to Adolescents


Programs for Public Assistance
AFDC
(Aid to Families with Dependent Children)
Food Stamps
PC II Prenatal care for pregnant teens
MEDICAID
Under 21
Pregnant Teens
General Relief Crisis

Employment

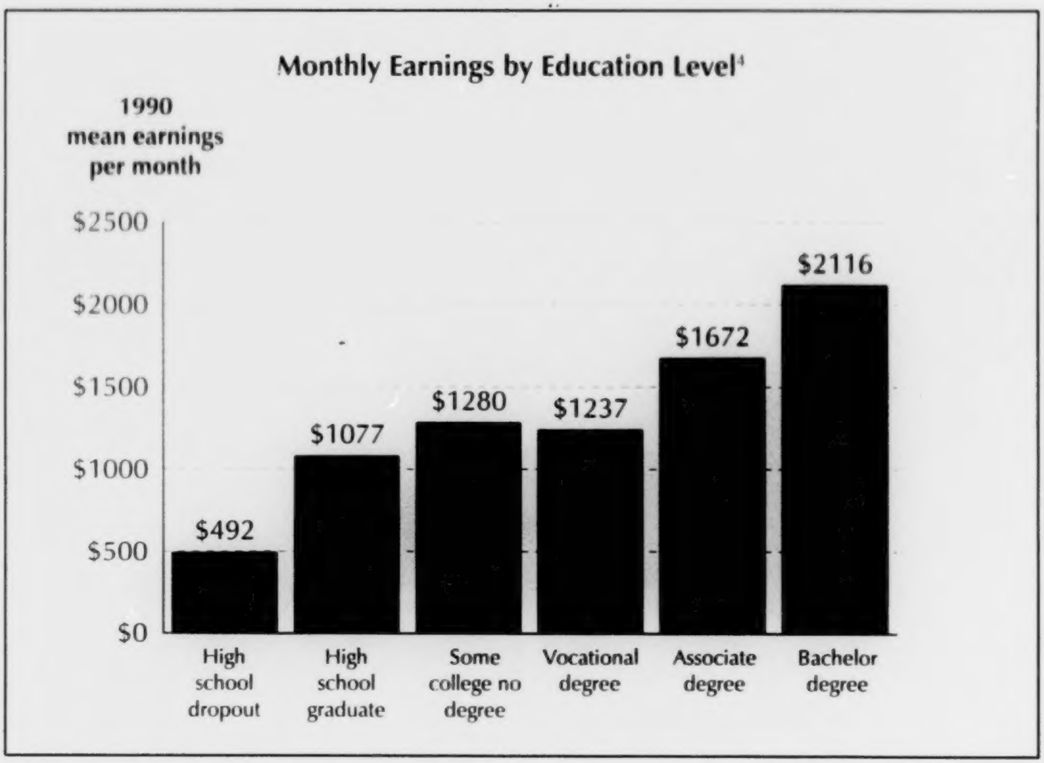
- In 1991 an estimated 37% of teenagers (16-19) were employed part- or full-time.[3]
- 75% of Alaska's employed youth work in either the retail trade (including restaurants) or the service industry.[1]
- While there is an abundance of entry level jobs in several urban communities, many rural areas have very few cash-paying jobs for any age.[1]
- The group that continues to find it difficult to find or keep a job is high school dropouts. *See dropping out in the "School Achievement" section.*

Joblessness

Alaska's Youth Ready for Work, Inc.,[14] a group of leading employers reported that many young workers don't perform well or are unable to find jobs for the following reasons:

- quality of work;
- lack of initiative;
- work attitudes;
- inability to work with others; and
- work habits.

Figure 2.3



Monthly Earnings by Education Level[4]

Runaways and Homeless

Risk Factors

Runaway and homeless youth have been described as having one or more of the following high risk factors in their background:

- physically and sexually abused;
- alcohol and drug abuse;
- emotional and mental health problems;
- chronic health problems including STDs;
- pregnancy and poor nutrition;
- abandoned or rejected by parents;
- truant, failing in school; and
- lack of future planning and independence.[6]

- Over 3,500 Alaska youth ran away from home in 1991. There were over 13,000 separate runaway incidents in the state that same year.[6]
- Young women run away more frequently than young men; in some regional locations females run away twice as often as males.[6]
- Average age of a runaway youth is 14.5 years.[6]
- Over 1,800 Alaskan adolescents were homeless in 1991.[7]
- Slightly more males are reported homeless than females except in Anchorage (70% male), Homer, and Kodiak (40% male).[7]
- Approximately 90% of homeless youth are 16-21 years of age.[7]

Table 2.1

1991 Regional Profile: Alaska Runaways by Gender

Community	Female	Male
Juneau, Fairbanks, Bethel, Nome	55%	45%
Kenai Peninusla	66%	33%
Barrow	70%	30%
Mat-Su, Kodiak, Anchorage	about 50%	about 50%

Reference: Division of Family and Youth Services[6]

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The consequences of substance use to adolescent growth and development are substantial. Adolescents have easy access to alcohol, tobacco, and other drugs. When intoxicants are used to deal with the stresses of adolescence, the teen does not learn healthy coping strategies. Poor educational performance due to having a hangover, being "high", and losing motivation can result in long-term, negative effects. Children learn from their role models, parental figures, and community members. Alaska has one of the highest alcohol consumption and alcohol-related death rates in the nation. Alcohol and other drugs play a significant role in other adolescent problem behavior.

Information on adolescent substance use was obtained from multiple sources, including the 1989 Adolescent Health Survey. Students surveyed were in grades 7-12, excluding Anchorage and Fairbanks.

Onset of Use

- Most drug experimentation occurs between ages 12-13 though each drug has its own initiation pattern.[7]

Table 2.2

Peak Age of Substance Experimentation by Alaska Teens

Substance used	Peak age
Smokeless and chewing tobacco	before age 12
Inhalants	before age 13
Cigarettes, alcohol, and marijuana	between ages 12-13
Other drugs (cocaine, stimulants, and halucinogens)	between ages 14-15

Reference: Bernard Segal[7]

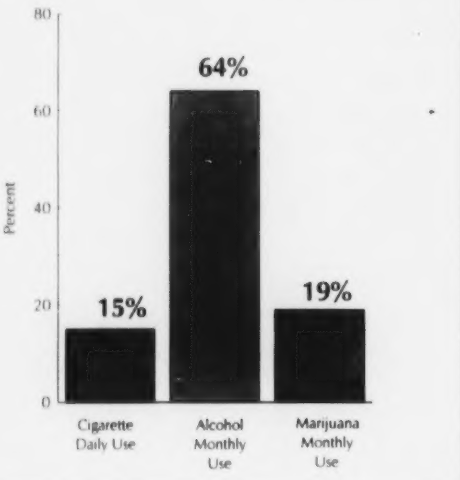
Pattern of Use

Substances used most often by teens are tobacco, alcohol, and marijuana.

- 34% of students surveyed who had ever drank alcohol, report they generally drank five or more drinks at one time.[3]
- 22% of students who drink, report they get drunk at least once a week.[3]
- 16% of males and 12% of females in communities under 2,500 use chewing tobacco daily.[1]

Figure 2.4

Alaska Teen Substance Use - 1988[2]



- 26% of Alaska teens report having used inhalants at least once.[7] Even experimental use of inhalants can cause permanent health damage (depending on the substances used and the method of inhalation).[4]
- Of those who report ever using inhalants, 48% of males and 27% of females report they get high at least once a week.[12]

Pattern of Use

Four major in-state studies were reviewed and compared: Segal 1988, Adolescent Health Survey 1989, Anchorage School District Surveys 1988 and 1990. This overview has deliberately focused on "past month" use rather than "ever used". "Past month" use gives a more accurate picture of regular or chronic users.

Table 2.3

Past Month Use - Cigarettes, Alcohol, Marijuana

Study/Survey Group	Year	Grades	Cigarettes	Alcohol	Marijuana
Alaska Segal - 10 school districts[2]	1988	7 - 12th	26%	64%	19%
Anchorage School District[5]	1988	8/10/12	25%	57%	20%
Anchorage School District[5]	1990	8/10/12	17%	40%	12%
United States Youth Risk Behavior Survey[6]	1990	9 - 12th	32%	59%	14%

Table 2.4

Chronic Alcohol Use and Chronic Smoking

Study/Survey Group	Survey Year	Grades	Problem Drinking Definition	Problem Drinking	Chronic Smoking Definition	Chronic Smoking
Alaska Segal - 10 school districts[2]	1988	7 - 12th	≥3 times a week	10.50%	>1 a day in last 30 days	14 - 15%
Anchorage School District[5]	1990	8/10/12	> 5 times on at least one occasion in last 30 days	17%	>1 a day in last 30 days	12% (1990) 14% (1988)
Adolescent Health Survey[1]	1989	7 - 12th	>5 times on at least one occasion or >3 drinks each occasion weekly	17%	daily	14% (16%females) (13%males)

Table 2.5

Past Month Use - Cocaine, Inhalants, Hallucinogens

Study/Survey Group	Survey Year	Grades	Cocaine	Inhalants	Hallucinogens
Alaska Segal - 10 school districts[2]	1988	7 - 12th	3%	4%	8%
Anchorage School District[5]	1988	8/10/12	3%	5%	5%
Anchorage School District[5]	1990	8/10/12	2%	4%	2%
United States Youth Risk Behavior Survey[6]	1990	9 - 12th	2%	not reported	not reported

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Parental Use

Research has identified parental substance use to be a significant factor in teen substance use.

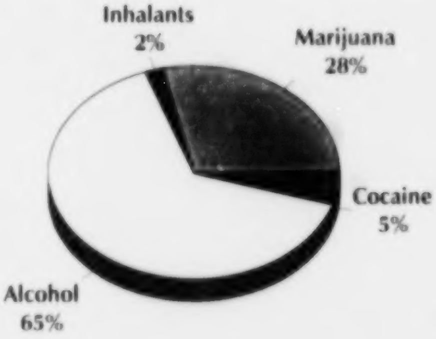
- Alaska has the fourth highest per capita alcohol beverage consumption in the United States.[11]
- Alaska has the second highest alcohol related mortality rate in the nation.[14] (Mortality from any alcohol-related disease: cirrhosis, alcohol dependence syndrome; alcohol psychosis, and alcohol poisoning).

The 1989 Adolescent Health Survey, provides information on parental use, as reported by students.

- 12% of parent(s) drink alcohol daily.[3]
- 11% of Alaskan students (7-12 grade) surveyed say they worry about their parent(s) drinking.[3]
- 6% of parent(s) use marijuana weekly or daily.[3]
- 38% of parent(s) smoke daily.[3]
- 21% of students say their parents have had problems within the past five years because of drinking or drugs.[3]

Figure 2.5

FY91 Primary Treatment Services
Alaska Youth 18 and Under*



*State funded treatment programs[9]

Treatment Services

- In FY91, 1,250 youth under 18 were served in state funded treatment programs.[9] (This represents a limited sample of the total population of youth who receive treatment. Data from private hospitals was not available.)
- 25% of youth receiving state funded treatment services were identified as polydrug users.[9]
- 6% of Alaska's 7-12th grade students report having been in alcohol or drug treatment.[11]

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) represents the severe end of the spectrum of disabilities caused by alcohol use during pregnancy. In the absence of the full syndrome, prenatal alcohol exposure has been associated with learning disorders, hyperactivity, short attention span, and lower IQ.[29]

- 17% of Alaskan women of childbearing age (18-44) are heavy drinkers. During any given month, a heavy drinker consumes more than 30 drinks, or 5 or more drinks on at least one occasion. Should these women become pregnant and continue to drink, they are at risk for delivering an alcohol-affected infant.[24]

Statewide FAS prevalence

- The percentage of teens affected by prenatal exposure to alcohol, is unknown. During adolescence the behavioral and learning problems of FAS persists, but the facial features of the syndrome disappear, making FAS difficult to identify.[26]
- Estimates for the state's population (Native and non-Native) have been calculated based on national rates and the Native Health Service. This data suggests that 29 FAS cases may be born each year in Alaska.[28]

Cost of FAS

- A total of 38 individuals with FAS (as verified through medical chart review) accounted for $690,000 in medicaid billings during a 2-year period, 1989-1990.[27]
- Lifetime cost for each Alaskan FAS birth was conservatively estimated in 1989 as $1.4 million.[28]

Alaska Native FAS Prevalence

A medical chart review of Alaskan Native children (identified through the Indian Health Service, state data sources, and a large pediatric practice) yielded a preliminary minimum FAS prevalence rate. A statistical technique was used to estimate a maximum prevalence rate for Alaska Natives, born 1978-1991, currently aged 1-14.[25,27]

- Observed minimum: 2.1 FAS cases per 1,000 live births[27]
- Estimated maximum: 6.6 FAS cases per 1,000 live births[25]

Alcohol's Link with Other Behaviors

- Abuse of alcohol and other drugs is the greatest cause of disability and perhaps death in adolescents and young adults.[8]

- 34% of Alaskan students (7-12 grade) who drink, report having driven after drinking.[12]

- 16% of Alaskan students (7-12 grade) who drink or use other substances, report having had an injury or accident due to their use.[13]

A 1992 comprehensive study by the Inspector General of the U.S. Department of Health and Human Services found a strong association between underage drinking, rape, sexual assault, suicide, and other harmful incidents.[15] Findings include:

- A U.S. Department of Justice survey found 32% of youth under 18 in long-term state-operated juvenile institutions in 1987 were under the influence of alcohol at the time of the offense.[16]

- Alcohol use is implicated in one- to two-thirds of sexual assault and acquaintance or date rape cases among teens and college students.[15]

- In a national survey of college students, almost 50% who said they had been victims of crime admitted that they had used alcohol or another drug before the crime occurred.[17]

- Alcohol is a contributing factor in the timing and seriousness of attempted youth suicides. One researcher found that drug and alcohol abuse is the most common characteristic of youth who attempt suicide.[18]

- A survey of high school students found that 18% of females and 39% of males say it's acceptable for a boy to force sex if the girl is drugged or drunk.[19]

- A 1990 survey of Massachusetts 16-19 year olds found that 49% were more likely to have had sex if they and their partner had been drinking. In addition, 17% used condoms less often after drinking.[20]

- Two national studies have linked youth alcohol use and drowning. Researchers found from 40% to 50% of young males who drown use alcohol prior to drowning.[21,22]

Table 2.6

Percent of Alcohol-Related Youth Fatalities	
Accidents	40%
Automotive	51% (under 21 years old)
Homicide	30%
Suicide	20%

National youth age 15-24; drug-related data not available[8]

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Establishing a positive, healthy approach to sexual behavior is critical for the prevention of early adolescent sexual activity and the related problems of teen pregnancies, childbirth, and sexually transmitted diseases. Adolescent sexual activity has profound long-term economic and social costs. Alaska teens report an early onset of sexual intercourse. This premature sexual activity results in a high teen birth rate, and serious concerns about sexually transmitted diseases.

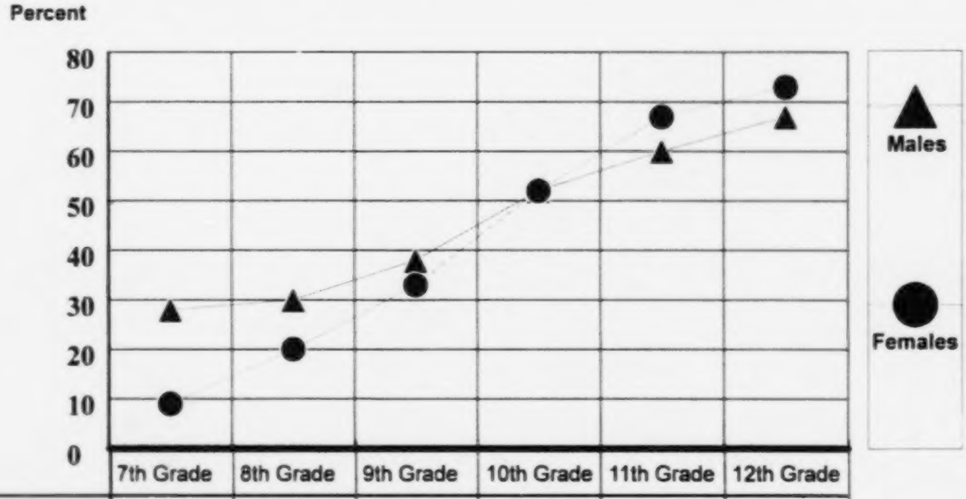
Some of the data on adolescent sexual behavior was obtained from the 1989 Adolescent Health Survey. Students surveyed were in grades 7 - 12, excluding Anchorage and Fairbanks.

Sexual Experience

- Alaska teens (grades 7-12) report an onset of sexual intercourse at an earlier age (females - 14, males - 13) than teens nationally (females - 17, males 16).[1,4]
- 25% of surveyed Alaskan 8th graders (junior high students) report having had sexual intercourse.[1]

Figure 2.6/Table 2.7

Percent of Students Reporting Having Had Sexual Intercourse*



		7th Grade	8th Grade	9th Grade	10th Grade	11th Grade	12th Grade
Females	Alaska[1]	9%	20%	33%	52%	67%	73%
	U.S.[2]	Not Available			43%	Not Available	67%
Males	Alaska[1]	28%	30%	38%	52%	60%	67%
	U.S.[2]	Not Available			53%	Not Available	76%

*Alaska teens who have ever experienced intercourse, does not imply frequency (1989).[1]

- Young women who have had multiple partners and who initiate intercourse at an early age face the greatest risk of developing cervical cancer, typically 6 - 20 years later.[21, 23, 32]

- A 1990 national survey found 35% of 9th -12th grade students report having had two or more sex partners during their lifetime. Four or more sex partners were reported by 19% of the same group.[5]

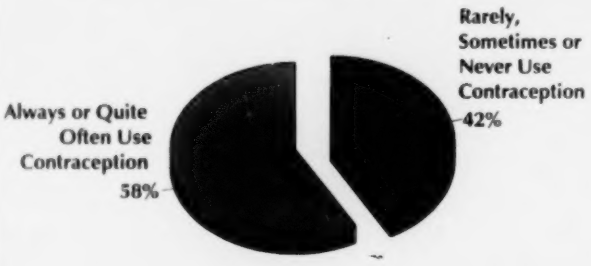
Contraceptive Use

- Most common contraception used by sexually active Alaska teenagers.[1]

· condoms	51%
· withdrawal	12%
· birth control pill	16%
· foam with condoms	3%
· no birth control	19%

Figure 2.7

Reported Contraceptive Use by Alaska Teens*



*Students grades 7-12 (1989)[1]

- Condoms are the most frequently used form of birth control: females 41%, males 58%.[1]

- A national study found among sexually active 9 - 12th grade students, 78% reported they (or their partner) used contraception at last intercourse.[2]

Table 2.8

Reasons for Not Using Contraception Among Alaska Teens Who Are Sexually Active

Reasons Not To Contracept	Male (n=344)	Female (n=346)
Having sex was unexpected, no time to prepare	32%	35%
Just didn't think of it	31%	22%
Partner doesn't want to use birth control	8%	5%
Embarassed to try to get birth control	4%	8%
It is my partner's problem, not mine	8%	5%
Didn't think I/she would get pregnant	6%	6%
Worry about side effects of birth control	2%	5%
Reference: Alaska Department of Health and Social Services [1]		

49

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Teen Pregnancy and Births

- Approximately one in ten Alaska females 15 - 19 (and one in five Alaska Native teen females) become pregnant every year.[24]
- More than 1,200 babies were born to teenage mothers in Alaska in 1991 and 1992.[24]
- Three teenagers a day give birth in Alaska; one a month is younger than 15; one in five is having her second, third, or fourth child.[6]
- In 1991, 33% of teenage births in Alaska were to mothers under 18.[19]

Pregnancy and Birth Rate Definition

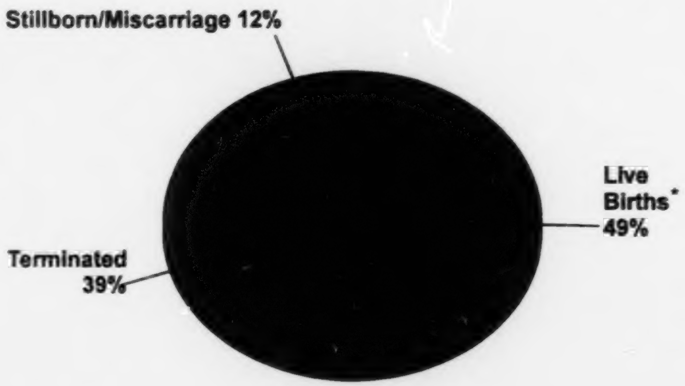
Pregnancy Rate: Number of conceptions (live-births + abortions + miscarriages) divided by the female population (15-19), times 1,000.

Birth Rate: Number of live births divided by the female population (15-19), times 1,000.

Teen birth rates and pregnancy rates are not synonymous terms. Alaska can identify birth rates, but it cannot identify precise pregnancy rates because the state keeps no record of pregnancies terminated by abortion, stillbirth, or miscarriage.

Figure 2.8

Teen Pregnancy Outcomes[15]
(national estimates)



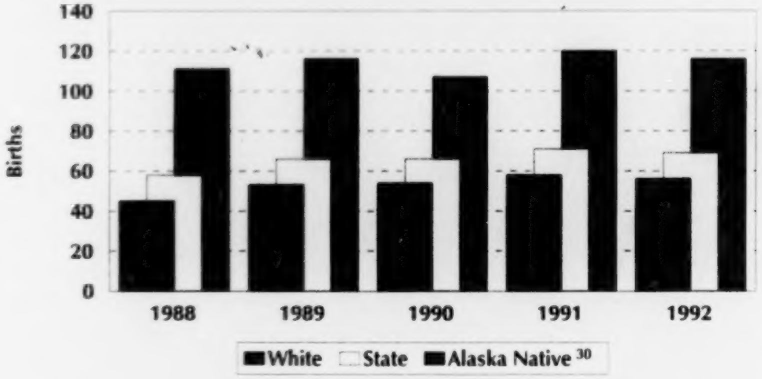
*An estimated 7% of unmarried teen mothers (ages 15 - 19) place their child for adoption.[16]

Teen Pregnancy and Births

- For Alaska teens ages 15-19, pregnancy and birth rates are on the increase. Birth rates fell in the mid-1980's but are rising again. 1991 estimates show a higher rate than anytime in the 1980's.[19,24]
- Estimated teen pregnancy rate, for the three year period 1990 - 1992: 140 pregnancies per 1,000 Alaska females ages 15 - 19 (Alaska's teen pregnancy rate is an estimated number derived by using national pregnancy outcome studies).[24,15]

Figure 2.9/Table 2.9

Comparitive Teen Birth Rates
Number of Births per 1,000 Females Ages 15-19



		1988	1989	1990	1991*	1992*
Alaska[30] Teen Births	White	45	53	54	58	56
	Native	111	116	107	120	116
	State	58	66	66	71	69
U.S.[3,10] Teen Births	White	42	49	51	Not Available	
	Black	112	110	113		
	U.S.	50	58	60		

*1991 and 1992 data are provisional; the Alaska Bureau of Vital Statistics cautions the reader that the data may change.

Public Cost of Teen Pregnancy and Births

- The public cost of teen parenting is defined as Food Stamps, Medicaid, and state and federal AFDC (Aid to Families with Dependent Children).[6] Other significant costs omitted from this estimate include:
  - education/job training;
  - child care;
  - child protective services for teen or child;
  - foster care;
  - housing;
  - psychological counseling; and
  - partial loss of mother and child as contributing members of society.
- Over 50% of the national AFDC budget is spent in households in which the mother was a teenager at the time her first child was born.[31]
- Nationally, public funds pay for the delivery costs of at least 50% of the births to teenagers.[26]

Annual Public Cost of Teen Parenting in Alaska

A 1988 cost analysis of teen parenting found:

- $51.4 million is spent to assist Alaska families that began when the mother was a teenager.[6]
- $4 million is spent annually to assist mothers who are currently teens.[6]
- More than $12,000 in public monies is spent annually to support each family headed by a teenager.[6]

1993 Teen Parenting AFDC Costs

- The number of teenage parents heading families and receiving public assistance has more than doubled since 1989.[19]
- In December 1992, 714 teen parents received AFDC services compared to 335 in January 1989.[19,7]
- The costs of AFDC for teen parents will be a minimum of $7 million in 1993.[19]
- In Alaska, for the three year period 1989-1992, 73% of mothers under age 20 were Medicaid recipients.[30]

Sexually Transmitted Diseases

- Teenage females are more prone to STD's than adults because of the anatomy and physiology of the adolescent cervix.[32]

Chlamydia

- Nationally, chlamydia infections to teens ages 15-19 occur six times as frequently as gonorrhea infections.[31] In 1992, Alaska adolescents ages 15-19 comprised 50% (92 of 184) of the positive chlamydia tests in four public health sites offering tests.[21] Infertility, ectopic pregnancy, and pelvic inflammatory disease are complications associated with chlamydia.[20]

Gonorrhea Rates

- Alaska teens age 15-19 have the highest Alaska age-specific rates of gonorrhea (535 cases per 100,000 in 1991). In that same year, young adolescents age 10-14 experienced a gonorrhea rate of 48 cases per 100,000.[11] While rates of gonorrhea have declined, many new penicillin-resistant strains have emerged.[22]

AIDS/HIV

- 25% of all Alaska AIDS cases are 20-29 years old. Because the incubation period may be ten years or longer, many of these young people were likely infected with HIV in their teens.[27]
- The total number of AIDS cases in Alaska ranged from 16-19 each year from 1986-1991 for all ages. The Centers for Disease Control and Prevention calculated a 1991 rate for Alaska of 3.4 cases per 100,000 people, compared to the national rate of 17.8 /100,000.[11]

Prenatal Care, Low Birth Weight, and Infant Mortality for Teen Mothers

In 1990, 44% of Alaskan teenage mothers received less than adequate prenatal care before delivery.[25] Babies born to teenage mothers are at a greater risk for low birth weight and infant death. Teen mothers are more likely to be underweight prior to pregnancy and do not gain weight during the pregnancy.[29]

Definitions

Low Birth Weight Rate: The number of babies born whose birth weight is less than 5 lb. 8 oz., divided by number of live births, times 1,000.

Infant Mortality Rate: The number of infant deaths (under one year of age)divided by the number of live births, times 1,000.

- Low birth weight babies per 1,000 females for the three year period 1988 - 1990.[9]

teens 15 - 19:	63/1,000
all ages:	48/1,000

- Infant Mortality per 1,000 births for the three year period 1988 - 1990.[9]

teens 15 - 19:	14/1,000
all ages:	10/1,000

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Mental health refers not only to the absence of mental disorders but also the ability to negotiate life's challenges without dysfunction. The prevalence of mental disorders among adolescents in Alaska is unknown at this time. Emotional disorders can contribute to many other health problems in adolescents. Teens suffering from emotional disorders are often less able to resist substance use, unprotected sex, and other antisocial, risk-taking behavior.

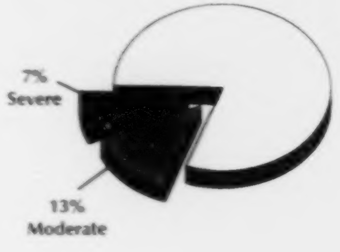
Suicide is the result of an inability to move through life's challenges. The suicide rate for Alaska teens is four times higher than the national average. For Alaska Native teens the suicide rate is ten times higher.

Some information on adolescent mental health was obtained from the 1989 Adolescent Health Survey. Students surveyed were in grades 7-12, excluding Anchorage and Fairbanks.

Figure 2.10

Adolescent Psychiatric Disorders[4]

(based on national estimates)



Psychiatric Disorders

- Prevalence of psychiatric disorders among adolescents in Alaska is undetermined.[4]
- Using national prevalence estimates and the 1990 census data, 16,000 Alaska adolescents (20%) may have some form of psychiatric disorder.[4]
- 5,600 Alaska adolescents (7% of the population) are estimated to be severely emotionally disturbed.[4]
- 6% of surveyed students grades 7-12 were determined to be "highly emotionally distressed" (experiencing two or more: extreme saddness, stress/ pressure, worry, or nervousness).[18]
- Nationally, 1% of females (12-18) are anorexic[14] and 3-19%[15] of high school and college females are bulimic. Long term mortality rates for chronic anorexia (as high as 20%) are among the highest for psychiatric disorders.[16,17]
  - 12% of Alaska students (grades 7-12) report they vomit at least monthly to control weight.[19]

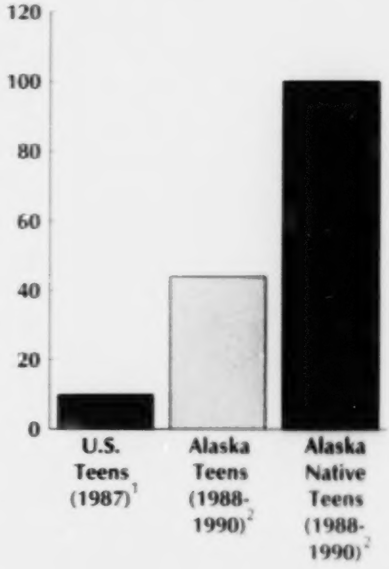
See Eating Disorders in the Physical Health section for more information.

Suicide Demographics

- Rate of suicide for Alaska youth (15-19) is four times higher than teens nationally.[1] The Alaska Native adolescent suicide rate is almost three times higher than the rate for white Alaskan teens.
- 142 Alaska youth (10-19) committed suicide between 1980-1989.[5]
  - 73% of suicides were male
  - 46% were Alaska Native
- According to the 1989 Adolescent Health Survey:
  - one in six teens report they have ever attempted suicide.[18]
  - 18% of teens report they know of a family member who attempted or completed a suicide.[18]
  - 45% of teens report that at least one of their friends has attempted suicide.[18]

Figure 2.11

Teen (15 - 19) Suicide Rate Deaths per 100,000



Definition

Suicide Rate: Number of suicides divided by the age-specific population, times 100,000.

Table 2.10

Number of Alaska Teen Suicides (15-19) by Ethnicity

Year/Race	White	Alaska Native	Other Ethnic Groups	State Total
1988	10	6	0	16
1989	10	10	1	21
1990	6	5	1	12
3-year Average Suicide Rate*	32 per 100,000	100 per 100,000	-	44 per 100,000

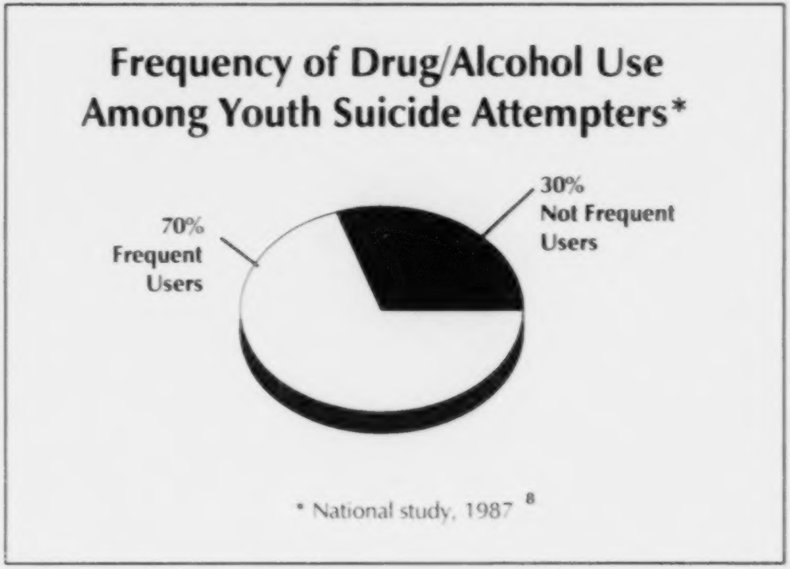
*Due to the relatively small number of suicides, these rates may vary from year to year, so a 3-year average rate was calculated.

Reference: Bureau of Vital Statistics [2]

Alcohol-Suicide Link

- An Alaska study (Hlady 1986) examined suicides of all ages.[3]
  - 59% of 169 suicides examined had detectable blood alcohol levels at autopsy.[3]
  - 79% of Native suicides studied had detectable blood alcohol level at autopsy.[3]
- An Anchorage injury study (Vermillian 1990) found females (15-19), outnumbered males 3 to 1 for nonfatal, self-inflicted injuries.[12]
- A 5 year study of Alaska Native suicides in Southwest Alaska (Marshall 1992) provides an indepth look at 66 rural suicides of all ages.[13]
  - Guns were involved in **90%** of all suicides.[13]
  - Alcohol was involved in **70%** of all suicides and **38%** of youth suicides.[13]
- A national study of youth suicide found drug and alcohol abuse to be the most common characteristic of teen suicide attempts. A high incidence of drug and alcohol abuse by the attempters' parents was also noted.[8]

Figure 2.12



* National study, 1987 [8]

Mental Health Services

Table 2.11

Adolescents Receiving Mental Health Services by Provider	
FY92 Mental Health Service Provider*	Number of Adolescents Served
Alaska Youth Initiative [7]	105
Alaska Psychiatric Institute [6]	185
Community Mental Health Center [6]	1,751

*This represents a limited sample of the total population of youth who received treatment services since private hospitals and clinicians did not provide documentation.

Table 2.12

Medicaid Reimbursed Mental Health Services FY92				
	6 - 14 years of age		15 - 20 years of age	
Services	Expense	No. Served	Expense	No. Served
Inpatient Psychiatric Service	$4.9 million	338	$2.7 million	264
Outpatient Mental Health Clinic Services	$1.5 million	1,075	$.7 million	554
Institutional Services for the Mentally Retarded	$.9 million	8	$1 million	9

Reference: Alaska Division of Medical Assistance [10]

Division of Mental Health and Developmental Disabilities

- In FY92, 1,936 adolescents age 10-19 received services from state funded mental health service providers.[6]
- Over half of the teen primary diagnoses are for family and social adjustment disorders.[6]
- In 1985 the Alaska Youth Initiative (AYI) was established to bring back severely emotionally disturbed (mentally ill, abused, delinquent, and behavior disordered) children placed out-of-state and provide in-state individualized, treatment services.

Department of Education

- In FY92, Alaska Department of Education provided special education services for 564 seriously emotionally disturbed and 322 mentally retarded students age 10-19.[11]
- The department does not keep records of how many adolescents are seen by counselors or peer helpers for mental health issues.

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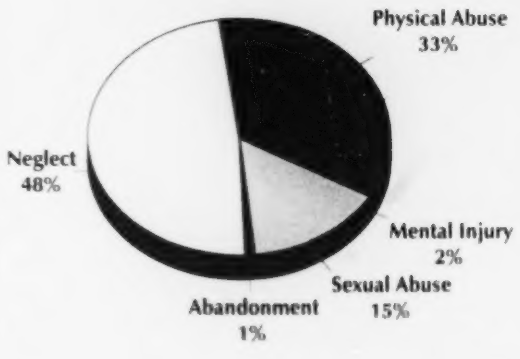
Alaska's child abuse rates are significantly higher than national rates. Abuse cases include physical and sexual abuse, neglect, mental injury, and abandonment. The long-term consequences of abuse pose serious risks to adolescent health. Preliminary data from Alaska juvenile crime experts indicate a significant increase in the number of crimes against persons committed by adolescents in FY93. The number of juvenile referrals (police reports) has steadily increased since FY89.

Some information on adolescent violence and crime was obtained from the 1989 Adolescent Helath Survey. Students surveyed were in grades 7-12, excluding Anchorage and Fairbanks.

Figure 2.13

FY92 Reports of Harm By Allegation[6]
Child Protective Services*



*Alaskans 0 - 17

Total - 11,509

Child Abuse and Neglect

- Alaska children are abused or neglected at an estimated rate of **63** alleged victims per 1,000 youth (ages 0-17) compared to a national abuse rate of **39** per 1,000 youth (1992).[6,5]

- Alaska's elevated rates of harm to children may be related to the following factors:[6]
  - excessive alcohol consumption;
  - the chronic shortage of mental health services to children and families.

- In FY92, 11,509 alleged cases of harm resulted in 8,996 child protection investigations (ages 0 - 17).[6] These investigations resulted in 3,574 substantiated reports of harm to children under 18.[7]
  - **Age:** 42% were adolescents ages 9-17
  - **Gender:** 53% were females; 47% were male
  - **Ethnicity**:

White	44%
Alaska Native	36%
Unknown	8%
Black	7%
Other	5%

- Cases of adolescent abuse and neglect are less likely to be substantiated than those of younger children according to national studies.[13]

Table 2.13

FY92 Final Outcome of 8.466 C.P.S Investigations

Type of Harm	Substantiated	Unconfirmed	Invalid
Neglect	45%	45%	10%
Physical Abuse	40%	50%	10%
Sexual Abuse	37%	55%	8%
Mental Injury	47%	48%	5%
Abandonment	78%	12%	10%

Reference: Child Protective Services, Alaska Division of Family and Youth Services [7]

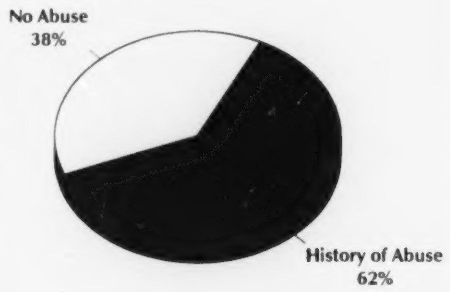
Effects of Violence on Subsequent Adolescent Behavior

Children are profoundly affected by the violence occurring in their homes.

- 63% of Alaska women who were abused during the previous year reported that their children were abused by the abuser.[2]
- A Washington study (Boyer 1992) examined the link between prior abuse and teen pregnancy.[9]
    - Young women with a history of physical or sexual abuse are more likely to become teen mothers than teens who had not experienced abuse.[9]
    - Teens with a sexual abuse history prior to pregnancy were more likely to have intercourse earlier, practice contraception less, use alcohol and other drugs more and abuse their own children, compared to pregnant teens who had not been abused.[9]
- An informal Alaska study found that 66% of the young pregnant women interviewed had experienced abuse prior to their pregnancy.[10]
- A 20-year national study found that abused and neglected children have a higher likelihood of arrest for delinquency, adult criminality, and violent criminal behavior than children who had not experienced maltreatment.[3]

Figure 2.14

Pregnant Teens with a History of Being Abused*



*Women (under 20) who had been physically or sexually abused prior to their first pregnancy as a teenager.[9]

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National Research on Abuse

- While several studies[3] have shown a link between child abuse and subsequent delinquency and violence, it is especially important to note that not all abused children grow up to become disturbed, violent, and delinquent teenagers or abusing parents.[4,13]
- Parents of adolescent victims are more likely than those of younger children to have higher educational levels and incomes above the poverty level.[13]
- High rates of prior maltreatment have been found among incarcerated youth, homeless or runaway youth, youth involved in drug abuse, and teens who became pregnant during early adolescence.[13]

Long term consequences of maltreatment

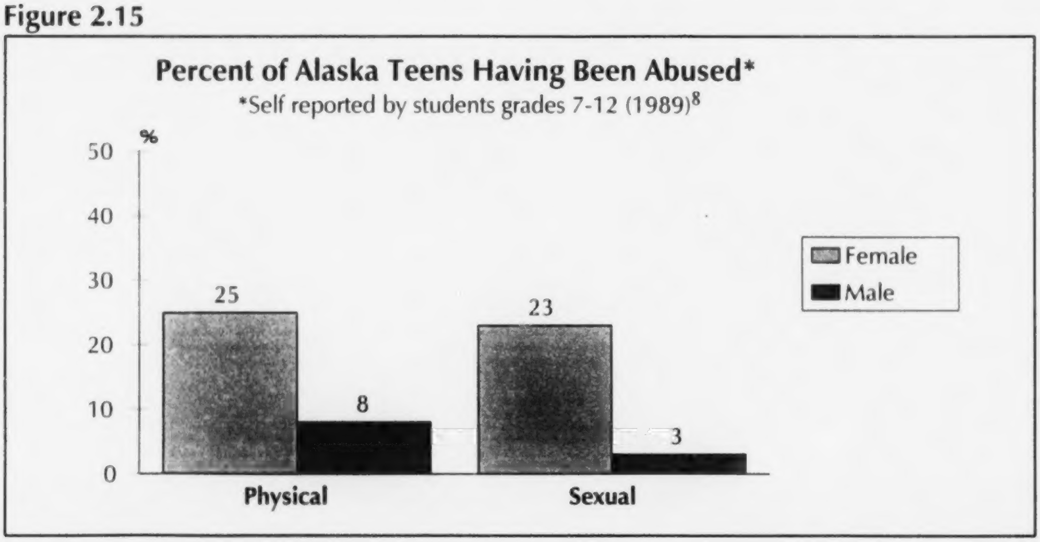
Long term consequences of abuse pose serious risks to adolescent health.[13] These include:

- premature or increased sexual activity;
- increased risk of unintended pregnancy;
- emotional disorders;
- attempts at suicide;
- increased risk of eating disorders;
- confused sexual identity;
- increased delinquent behavior; and
- drug and alcohol abuse.

Self Report of Abuse

- Less than one third of Alaska students who have been abused report they have told someone.[8]
- In FY91, 409 teens (ages of 13-17) were served by Council on Domestic Violence and Sexual Assault programs.[14]

Figure 2.15



Percent of Alaska Teens Having Been Abused*

*Self reported by students grades 7-12 (1989)[8]

Juvenile Crime

- In FY92, 7,168 youth probation referrals were made. Most referrals (police reports) consist of property crimes and liquor violations.[11]

- Characteristics of FY92 youth probation referrals:[11]

  - **Age**:
    69% were between ages 14-17.

  - **Gender**: arrests were 69% male; 31% female.

  - **Ethnicity**:

60%	White
25%	Alaska Native
7%	Black
7%	Other/Unknown

Figure 2.16

FY92 Alaska Youth Probation Referrals "Juvenile Arrests" by Category[11]

Total = 7,168

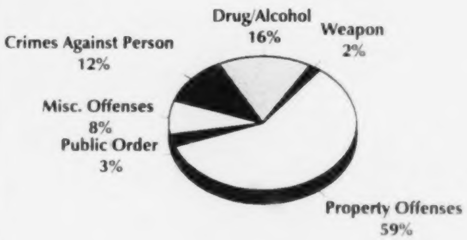
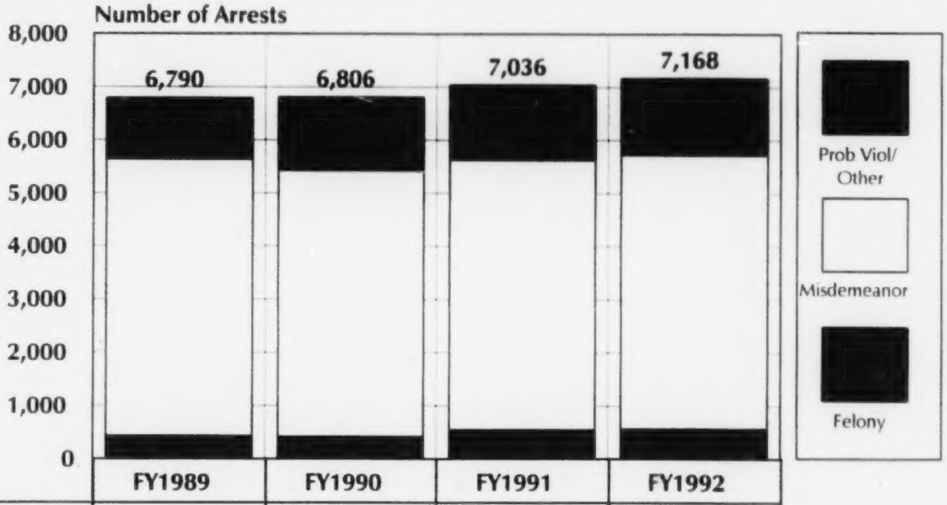


Figure 2.17/Table 2.14

FY89-FY92 Youth Probation Referrals[11]
(Police Reports of Criminal Activity by Youth Under 18)

some youth are arrested more than once



	FY1989	FY1990	FY1991	FY1992
Felony	1,143	1,374	1,404	1,437
Misdemeanor	5,216	5,015	5,083	5,165
Prob Viol/Other	431	417	549	566

Table 2.15

FY92 Police Reports of Criminal Activity by Alaska Youth Under Age 18
Total = 7,168

Crime Category	**Number of arrests [11] % misdemeanor % felony**	**Most often committed crimes by teens per category [1]**
Property	4,238 cases	
	Misdemeanor 75%	Shoplifting, joyriding.
	Felony 25%	Trespassing, burglary, theft
Drug/Alcohol	1,158 cases	
	Misdemeanor 96%	Possession and consumption of alcohol,
	Felony 4%	Possession and/or sale of most drugs
Crimes Against Persons	876 cases	
	Misdemeanor 69%	Reckless conduct, simple assault
	Felony 31%	Aggravated assault, sexual abuse, rape, robbery
Miscellaneous Offenses	563 cases	
	All violations	Probation violation 70% Other 30%
Public Order	196 cases	
	Misdemeanor 84%	Disorderly conduct, Harassment
	Felony 16%	Bomb threats
Weapon	133 cases	
	Misdemeanor 90%	Concealed weapon
	Felony 10%	Discharge of a weapon

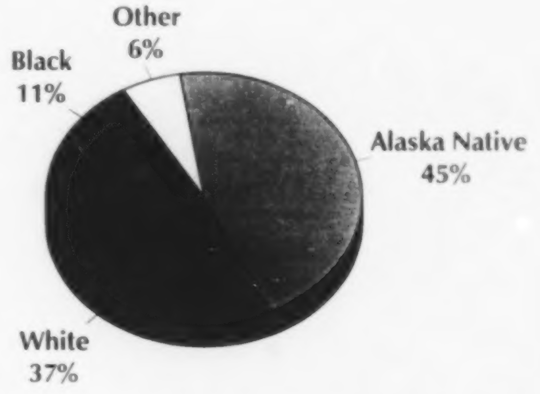
Youth Detention

In FY93, youth detention services were provided in 5 facilities (Anchorage, Fairbanks, Juneau, Nome, and Bethel).[12]

- 1,311 accused juvenile offenders were provided secured detention pending court appearance.[12]
- 96 juvenile offenders were provided supervision and rehabilitation in secure, long-term facilities.[12]
- Juvenile detention characteristics:[12]
  - **Age:** 75% were between ages 15-17
  - **Gender:** 74% male; 26% female

Figure 2.18

FY92 Juvenile Detention by Ethnicity[11]



70

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Over half of adolescent deaths are a result of unintentional injuries. The most frequent causes of adolescents' unintentional injuries include: motor vehicle crashes, falls, sports accidents, fire, water and poisoning. Alcohol and other drugs play a significant role in many injury deaths. Motor vehicle injuries, in particular, have profound, long-term socioeconomic costs.

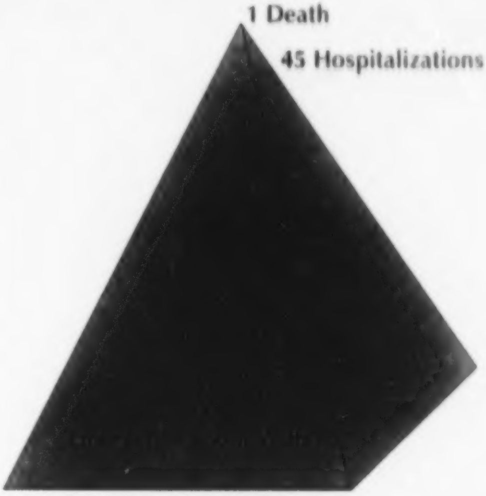
Some of the data on adolescent unintentional injuries was obtained from the 1989 Adolescent Health Survey. Students surveyed were in grades 7 - 12, excluding Anchorage and Fairbanks.

Injury Overview

- Alaska has the highest incidence of youth (age 0-14) injury deaths among the fifty states.[1,2]
- Deaths as a result of injuries are just the tip of the iceberg. Nationally, for every injury fatality (ages 0-19) there are 45 hospital admissions and 1,300 emergency room visits.[4]
- Between 1980 and 1989, 664 adolescents (ages 10-19) died as a result of some type of intentional or unintentional injury (76% were male; 35% were Native).[3]
- Motor vehicle crashes and drownings were the greatest causes of unintentional deaths for Alaskan youth 10-19 between 1980 and 1989.[3]

Figure 2.19

Fatality-Injury Pyramid
Ages 0 - 19*



*National study[4]

- Of students (grades 7-12) who ride a motorcylce at least once a month, 37% of males and 55% of females report rarely or never wearing a helmet.[8]

Table 2.16

Unintentional Injury Deaths
Alaskans (10-19)
1988 - 1990

Year	Unintentional Injuries/Deaths	Rate per 100,000
1988	35	46
1989	45	59
1990	31	39
3-year Average	-	48

Reference: Bureau of Vital Statistics[10]

Injury Overview

Definition

Unintentional Injury Death Rate: The number of deaths due to unintentional injuries divided by the age-specific population, times 100,000.

Motor Vehicle: includes cars, trucks, 3- and 4-wheelers, snowmachines, and motorcycles.

- Adolescent deaths may be divided into two general categories:

  1. Those due to pre-existing conditions, infections, or disease;

  2. Those as a result of injuries either intentional (suicides, homicides) or unintentional (all potentially preventable "accidents"). Table 2.17 lists the major causes of injury deaths to Alaskan adolescents.

Table 2.17

Causes of Adolescent Injury Deaths, Alaska, 1980 - 1989

Fatal Injury Causes	All Adolescents Ages 10 - 19	Young Adolescents Ages 10 - 14	Older Adolescents Ages 15 - 19
Motor vehicle crashes	214	44	170
Suicide	142	12	130
Drowning	112	25	87
Homicide	43	5	38
Other	94	29	65
Aircraft	24	6	18
Alcohol Poisoning	19	1	18
Fire	16	8	8
Total	664	130	534

Reference: Causes of Death in Alaska, 1950, 1980-1989 [3]

Motor Vehicle Crashes

- Between 1980 and 1989 motor vehicle crashes killed more Alaska teenagers than any other cause of death.[3]

- In a ten year review of teenage motor vehicle fatalities, 64% were male and 21% Native.[3]

- Teens 16-20 (representing only 7% of all licensed drivers) were involved in14% of all automobile crashes.[5]

- 1,180 adolescents 11-20 were injured (11 were killed) in 1991 automobile crashes.[6]

- "Automobile" refers to any motorized vehicle used on a public roadway (it does not involve off-road crashes, i.e. 3- and 4-wheelers and snowmachines).

Drinking and Driving

- 34% of students who drink report having driven after drinking.[8]

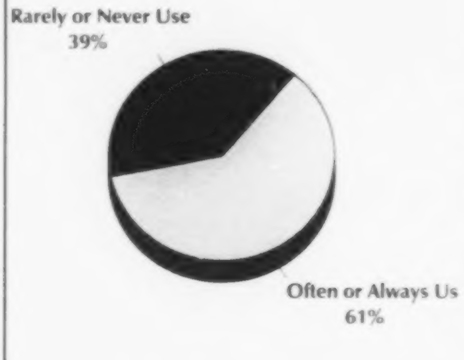
- 11% of documented alcohol related automobile crashes were caused by drivers age 16-20 (of drivers age known).[2,6]

- 75% of adolescent alcohol involved automobile crashes were caused by male drivers 16-20.[2,6]

- Of those males that drink, 40% report they have driven after drinking (7 - 12 graders).[8]

Figure 2.20

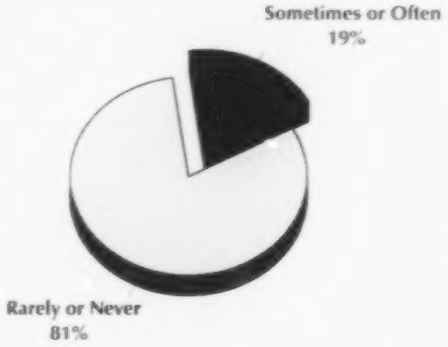
Safety Belt Use by Alaska Teens*



*Students grades 7 - 12 (1989)[8]

Figure 2.21

Alaska Teens Who Ride With A Drinking Driver*



*Students grades 7 - 12 (1989)[8]

Injury Link with Alcohol

- Alcohol plays a significant role in the leading causes of teenage death (accidents, homicides, and suicides).[9]

Table 2.18

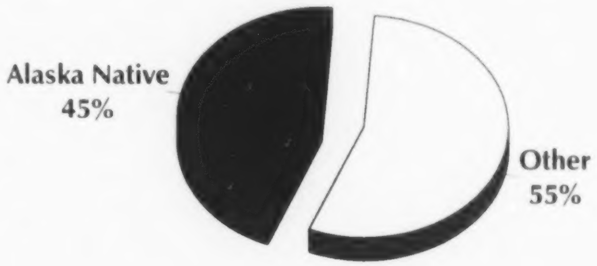
Percent of Alcohol-Related Youth Fatalities*	
Accidents	40%
Automotive	51% (under 21)
Homicide	30%
Suicide	20%

*National youth 15-24, drug-related data not available. [9]

- Between 1980-1989, drowning was the second leading cause of unintentional injury deaths to adolescents 10-19.[3]
- An early Alaska study (Annerud 1981) found the highest drowning rates for all ages occurred in the Northern and Southeast regions (commercial and subsistence fishing and hunting regions).[7]
- 95% of adolescent drowning victims are male.[3]

Figure 2.22

Alaska Drowning Victims by Ethnicity*



*Youth ages 10 - 19[3]

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Quality nutrition, regular physical activity, and abstinence from smoking and alcohol are cornerstones in developing and maintaining physical health during adolescence. Establishing positive lifelong health habits is critical for the prevention of chronic disease (heart disease, cancer, and stroke) later in life.

Information on adolescent physical health was obtained from the 1989 Adolescent Health Survey with the exception of the disability section. Students surveyed were in grades 7-12, excluding Anchorage and Fairbanks.

Eating Disorders and Attitudes

Concern with weight is a common problem among adolescents and can mark the beginning of a continuum of disordered eating behaviors and attitudes. If untreated, eating disorders can result in significant morbidity and mortality.[9]

- Nationally, 1% of females (12-18) are anorexic[7] and 3-19% of high school and college females are bulimic.[8]

Eating Habits

Poor dietary practices which may begin in adolescence are linked to the estimated 375,000 annual deaths (and $65 billion in related health care costs) due to heart disease, cancer and stroke. This dietary risk factor has an impact similar to that of tobacco for premature death.[4]

- Eating habits are extremely variable among adolescents. During the teen years 45% of adult skeletal mass is formed.[11] Poor eating habits are associated with increased risk of overweight, underweight, anemia, and dental cavities.[12]
- 23% of Alaska students surveyed eat fruits and vegetables less than once daily (current recommendation are 5 or more servings daily).[1]
- 40% of Alaska students eat "junk food" 3 or more times daily (sweet or salty snacks).[1]
- 20% of students (outside of Anchorage and Fairbanks) report eating subsistence foods daily.[6]

Table 2.19

Common Eating Disorders and Attitudes Among Alaska Adolescents*

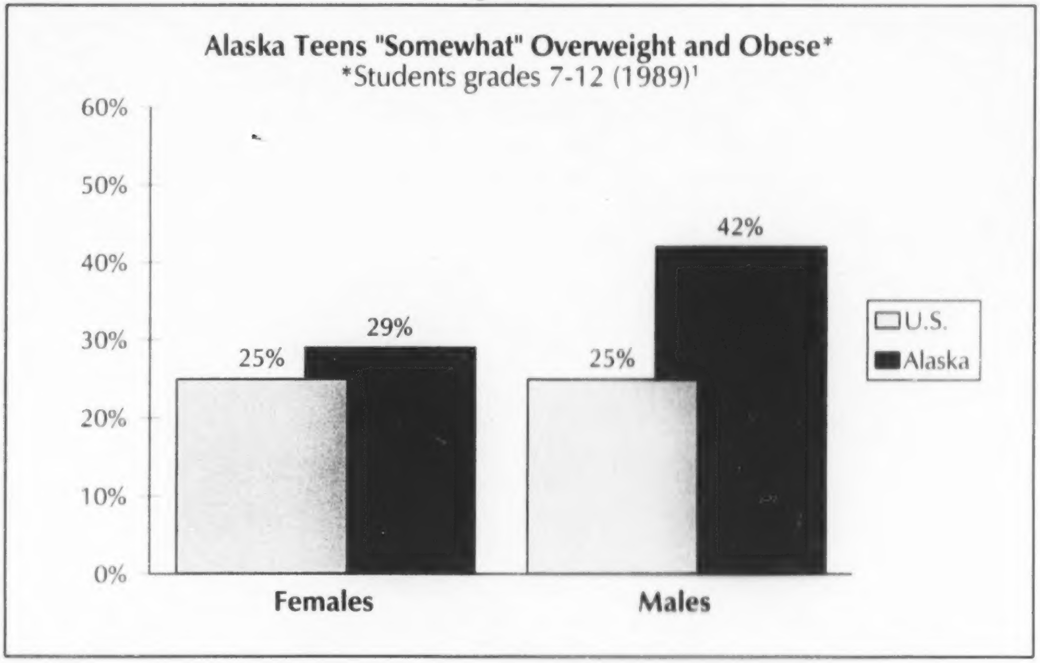
Teens Ages 12 - 19	Males	Females
Feel overweight	11%	31%
Feel underweight	34%	11%
Very dissatisfied with weight	15%	33%
Dieted at least 10 times in the past year	3%	10%
Have ever binged	17%	31%
Have ever induced vomiting	10%	14%
Fear not being able to stop eating once started	6%	16%

* When at appropriate weight for height; students grades 7 - 12 (1990) 6

Body Weight

- 60% of Alaska females and 45% of males were at the appropriate weight for their height.[1]
- Nearly 35% of Alaska teens were somewhat overweight or obese.[1]
- A study of Athabaskan and Fairbanks/ Interior teens, (12-19) found 18% of those surveyed to be overweight (22% female, 15% male).[3]

Figure 2.23



Alaska Teens "Somewhat" Overweight and Obese*

*Students grades 7-12 (1989)[1]

Table 2.20

Comparative Alaska/U.S. Adolescent Body Weights by Gender[1]				
	Males		Females	
Teens 12 - 19	Alaska	U.S.	Alaska	U.S.
Underweight	13%	25%	11%	25%
Somewhat Overweight*	26%	15%	15%	15%
Obese*	15%	10%	14%	10%

*Based on student reports of their height and weight whether an individual was underweight (0-25%), somewhat overweight (75-90%), or obese (90-100%). Deviation from expected values based on national norms (National Centers for Health Statistics, 1987).

Reference: State of Adolescent Health[1]

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Fitness

- 38% of Alaska students (45% females; 30% males) do not get adequate exercise ("breaking a sweat" three times a week).[6]

Tobacco

- 14% of surveyed Alaska students (16% female and 13% male) smoke cigarettes daily.[1]
- Chewing tobacco is used daily by 6% of students surveyed. (12% female and 16% male in communities less than 2,500 people.)[2]

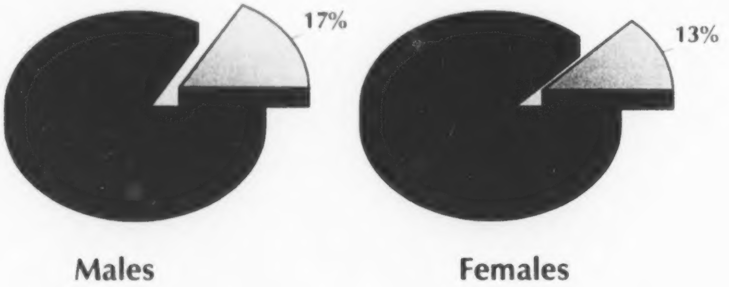
Preventative Health Care

- 71% of Alaska students reported they had received a physical exam in the last two years.[1]
- In rural communities (<2,500 people), 62% of students had received a recent physical exam.[1]
- In urban communities (2,500+ people, excluding Anchorage and Fairbanks), 75% of students received a recent physical exam.[1]

Figure 2.24

Preventable Behavioral Risk Factors Leading to Chronic Disease Teens Having Four or More Behavioral Risk Factors*

(overweight, poor nutrition, tobacco use, inadequate exercise)



* Alaska students grades 7-12 (1989) [1]

81

Disabilities

- 8,083 Alaska students (10-17) received special education services through their local school district in FY92. [10] Services are provided for the following handicapping conditions:[10]
  - hard of hearing;
  - speech or language impaired;
  - orthopedically impaired;
  - visually handicapped;
  - deaf;
  - mentally retarded;
  - traumatic brain injury;
  - emotionally disturbed;
  - multi-handicapped; and
  - other health impaired.

- It has been estimated that almost 9% of youth under 21 are in need of specialized health care (chronic conditions include muscle/skelatal, hearing impariment, speech defects, asthma, diabetes, and epilepsy; excludes: blindness, Down's Syndrome, and heart disease)[13]

- Using 1990 census data, it is estimated that 6,900 adolescents have chronic conditions likely to result in moderate to severe activity limitation.

- 5% of students in grades 7 - 12 report limitations in school activities due to a physical condition or health problem. 8% of students report some limitation in use of arms or legs.[6]

Table 2.21

Health Conditions
Limiting School Activities of Alaska Adolescents*

Category	Condition	Percent of Students
Nerve/Sensory	hearing impairment	8%
	speech problems	10%
	learning disabilities	11%
	seizures/convulsions	3%
Emotional/Somatic	nervous/emotional problems	27%
	abdominal problems	31%
	headaches	80%
Chronic	diabetes	2%
	allergies/hay fever	23%

*Students grades 7-12 (1989)[1]

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Academic test scores (ITBS and SAT) for Alaska adolescents are on par or slightly above national norms. Approximately one quarter of entering 9th graders will not graduate from high school. Alaska Native students in urban areas are 2-1/2 times more likely to drop out of school than their rural counterparts. School failure at an early age appears to be a major precipitating event in establishing adolescent problem behavior. Long-term employment opportunities are significantly reduced for high school drop outs.

Some information on adolescent school achievement was obtained from the 1989 Adolescent Health Survey. Students surveyed were in grades 7-12, excluding Anchorage and Fairbanks.

School Enrollment

- 45,039 students were enrolled statewide in grades 7-12 in 1990-91 school year.[1]
- While 72% of the students in grades 7-12 are enrolled in Anchorage, Fairbanks, Juneau, Kenai, or Mat-Su schools, 80% of the early leavers population (dropouts) came from one of these districts.[1]
- 53% of all students (K-12) are enrolled within the Anchorage and Fairbanks North Star Borough School districts.[7]

Supplemental Programs

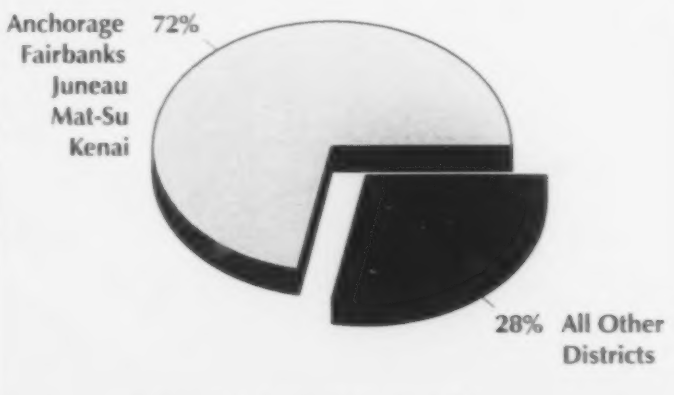
- Over 20% of dropouts are eligible for supplemental special educational programs.[5]
- Special educational services are provided to approximately 12% of enrolled K-12 grade population.[5]
- In FY92, 8,083 students (10-17) received special education services through their local school district.[5] See pages 69-74."Physical Health" section, for further details.

Alternative School Programs

In the 1992-93 school year approximately 15 alternative schools provided services to teens in Alaska. The number of alternative schools is on the increase as school districts restructure to meet the needs of all students.[6]

Figure 2.25

School Enrollment by Urban/Rural Districts*



*Students grades 7-12 (1990-91 school year)

Academic Test Scores

Standardized academic tests provide a basis to compare Alaska adolescents to their counterparts in the rest of the country. Standardized tests, however, have some inherent biases. Lower test scores are associated with high rates of students who live in homes where English is a second language, with cultural differences between the community and the school, and with high concentrations of families who are poor.

SAT Scores
(Scholastic Achievement Scores)

In the 1992-93 school year 49% of Alaska high school graduates took the SAT test. This nationally-normed, multiple-choice test is used to predict how well a student may do academically as a freshman in college.

Table 2.22

High School SAT Scores
1992-1993 Averages*

	Math	Verbal
Alaska Students	477	438
U.S. Students	478	424

*Highest possible score for each section is 900 [18]

ITBS Scores
(IOWA Tests of Basic Skills)

In 1991-92 more than 7,673 eighth grade Alaska students took the ITBS tests. Basic skills in reading, math and language arts are assessed and compared to national norms.

Table 2.23

ITBS 8th Grade Scores
Percentage of Students in Top and Bottom Quartiles

	Bottom Quarter		Top Quarter	
	Alaska	U.S.	Alaska	U.S.
Reading	21%	25%	32%	25%
Math	20%	25%	28%	25%
Language Arts	22%	25%	26%	25%

Reference: Alaska Department of Education [19]

Table 2.24

Relationship of Self-reported School Performance to Selected Risk Factors*

Risk Factors	Above Average School Performance 43.5%	Below Average School Performance 8.2%
Daily/Weekly Cigarette Use	11%	35%
Daily Weekly Alcohol Use	10%	21%
Daily Weekly Marijuana Use	4%	15%
Ever Had Sexual Intercourse	33%	52%
Ever Caused/Gotten Pregnant	3%	9%
Feel Extremely Hopeless	7%	16%
Would Like To Commit Suicide	4%	13%
Have Attempted Suicide	14%	27%
Ever Been Sexually Abused	13%	20%
Ever Been Physically Abused	12%	24%

*Alaska students grades 7 - 12 (1989) [17]

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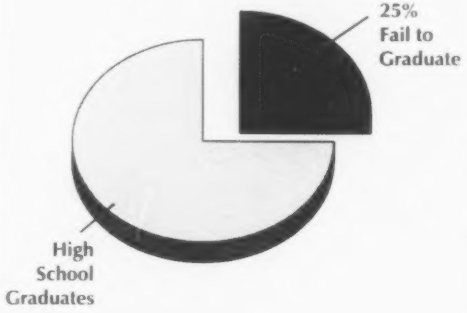
Dropping Out

- It is projected that **25%** of the Alaska 1990-91 ninth grade class will leave school prior to graduation.[1]
- 2,199 students in grades 7-12 dropped out of school, in the 1990-91 school year.[1]
- Alaska Native students from the urban school districts of Anchorage, Fairbanks and Juneau have the highest dropout rate.[2]
- National studies have found a high correlation between dropping out and teen pregnancy.[3,4] Young women who give birth in grades 7-12 complete an average fewer years of school, are less likely to earn a high school diploma, and are less likely to go on to college than those who delay childbearing until their twenties. [2,3]
- A 1990 Alaska study interviewing 115 young women who dropped out of school reported four major related factors:[8]
    - emotional, physical, and sexual abuse;
    - stereotyping and discrimination (based on race, age, gender, pregnancy, and economic status);
    - low self-esteem; and
    - isolation/alienation.

Figure 2.26

Alaska High School Dropouts*



*Estimated percentage of high school freshmen in 1990-91who will not graduate[1]

Table 2.25

Alaska Annual "Early Leaver" (Drop-out) Rate, by Ethnicity (Grades 7 - 12)

Ethnicity	Annual Drop Out Rate (%)*
Asian	3.7
White	4.4
Black	5.8
Hispanic	6.1
American Indian/Alaska Native	6.3
Anchorage, Fairbanks, Juneau Districts	12.6
Districts OUTSIDE Anchorage, Fairbanks, and Juneau Districts	4.7
Alaska Statewide Total	4.9

*Percent represents the number of early leavers (drop out), by ethnicity divided by the October 1, 1990 enrollment count by ethnicity.

Costs of Dropping Out

- Unemployment rates for high school dropouts are more than twice those for high school graduates.[16]
- Nationally, each year's class of early leavers will, over their lifetime, cost the nation about $260 billion in lost earnings and foregone taxes.[15]
- The lifetime lost earnings from Alaska's 1991 dropouts is over $500 million (using national estimates).[1]
- National estimates indicate that dropouts require 35% more social services than high school graduates.[1]
- Nationally, 82% of all prisoners are high school dropouts. In Alaska, it costs an average of $35,000 annually to maintain each prisoner.[1,15]
- Over a ten year period, earnings for male dropouts have decreased 12%, for high school graduates 9%, while college graduates earnings rose 10%.[11]
- In a lifetime, a male high school dropout will earn $260,000 less than a high school graduate; a female will earn $200,000 less.[11]

Table 2.26

Educational Attainment and Employment Status*

Education Level/Status	Employed	Looking for Work
Non high school graduate	52	13
High school graduate	76	9
Some college	85	5
College graduate	90	5

*National study; ages 16 - 24 (1989)[14]

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Research and Data Needs

This review of Alaska's adolescent health status is by no means complete. Many questions are left unanswered, often due to lack of complete statewide data. The Division of Public Health and the Adolescent Health Advisory Committee recognize the following areas of significant concern; but adequate information was not available at the time of publication.

Opportunities for prevention and early intervention will be greatly enhanced by periodic, comprehensive adolescent health surveys to identify problems, patterns, and trends in health status. The potential association between adolescent health problems needs to be examined (physical/sexual abuse, substance abuse, casual sexual behavior, teen pregnancy, suicide, intentional and unintentional injuries, and school drop out). There is a tremendous need for systematic, rigorous evaluation of adolescent health programs and services to identify short term and long term outcomes. This is critical to determine the efficacy and cost effectiveness of specific interventions.

If the reader is aware of Alaska studies in the following areas please contact:

Adolescent Health Coordinator

Alaska Department of Health
and Social Services
Division of Public Health
Section of Maternal, Child
and Family Health
1231 Gambell St.
Anchorage, AK 99501
279-4711

The research and data needs outlined on pages 82-85 are not all inclusive or listed by priority.

Substance Use Research

- The prevalence of substance use among adolescents including trends and patterns of use. "Past month use" and "chronic use" data are particularly needed.
- Data examining the relationship between physical/sexual abuse and subsequent substance use during adolescence.
- The incidence and prevalence of FAS and alcohol-affected infants and adolescents and among teenage mothers.
- The prevalence, trends, and patterns of adolescent substance abuse residential and out-patient treatment statewide (private and public hospitals).

The long term social, economic, and health consequences of substance abuse on the state as a whole (including medical expenses — acute and long-term care, rehabilitation, loss of income and productivity, and legal system overload).

- The effectiveness of current Alaska laws regarding underage alcohol consumption.
- The effectiveness of existing substance use prevention programs, including "ever use", "monthly use", and "chronic use" categories.
- The effectiveness of smoking cessation programs used by Alaska adolescents.

Sexual Activity Research

- The patterns and trends of adolescent sexual activity (those who have ever had intercourse, those who have had intercourse in the past month, those who have had intercourse and chosen to abstain) and their contraceptive use.
- The incidence and trend of teenage pregnancy between the ages of 10-14 and 15-19 including pregnancy terminations.
- The incidence, trends, and circumstances of sexual abuse, date rape, and other forced sexual encounters among teens.
- The impact of pregnancy on teenage mothers and fathers on completing high school or obtaining a GED by age 25.
- An updated cost analysis of teen pregnancy/parenting to the State of Alaska.
- Effectiveness of family life education programs, including:
    - delay the onset of intercourse among adolescents;
    - increase the number of teens (who have been sexually active) who chose abstinence;
    - increase contraceptive use among sexually active teens;
    - increase use of "safer sex" practices; and
    - decrease repeat pregnancies among teen parents.

Mental Health Research

- The patterns and prevalence of mental disorders among adolescents.
- The incidence and trends in suicide and suicide attempts during adolescence.
- The prevalence of adolescents recieving mental health services from public and private care facilities. The presenting problems and diagnosis of adolescents receiving mental health services.
- The number of and cost effectiveness of community mental health support services for adolescents.
- The number of "adolescent-designated beds" in hospitals.
- The effectiveness of current adolescent suicide interventions.
- The effectiveness of providing mental health services in the school setting on adolescent depression, suicide, and adjustment disorders.
- The effectiveness of peer helper programs in reducing adolescent depression, suicide, and adjustment disorders.
- The effectiveness of removing children from the home to increase long-term health and reduce dysfunction.

Violence and Crime Research

- The frequency, pattern, and trends of crimes against persons committed by adolescents (10-19) including demographics on gender, age, ethnicity, and location.
- Frequency and patterns and trends of crimes against property, DWI's (driving while intoxicated) and other drug-related offenses committed by adolescents.
- Incidence and trend data of race-related or "hate" crimes, including demographics of offenders and victims.
- The role of substance use in criminal offenses committed by juveniles.
- The prevalence of violence in the home (physical, sexual abuse, neglect, mental injury, and abandonment) committed against an adolescent.
- The prevalence of violence in the home (physical, sexual, and emotional abuse) committed by the adolescent against other family members.
- Statewide surveillance of violent acts (crimes against persons and property within the school setting. The prevalence of students carrying weapons onto school grounds.
- Legal trends in the courts for juvenile offenders including: the number of cases, criteria for screening cases, disposition of cases, and repeat offenders.

Violence and Crime Research
(continued)

- Cost analysis of the impact of crime by adolescent offenders including: victims medical, rehabilitation, incarceration/ custodial care expenses, property damage, and loss of income/ productivity.
- Effectiveness of violence prevention programs.
- Effectiveness of remediation programs within the institutional setting on recidivism.

Unintentional Injuries and Fatalities Research

- Complete and accurate data on the nature and circumstances of injuries including:
    - the role of substance use;
    - use of personal protective equipment (seat belts, PFD, helmets);
    - patterns and trends in recreational injures and transport-related injuries including motor vehicle, ATV, snowmachines, motorcycles, and bicycles;
    - routine coding of the external causes of injury (minimize the use of the injury category "undetermined" by health care providers).
- Data on the long-term physical and mental outcome of injuries resulting in permanent disability and surveillance of spinal cord and head injuries.
- Cost analysis of adolescent injuries including: acute medical expenses, rehabilitation, long-term care, loss of income/ productivity, and maintenance.
- Data on the effectiveness of injury prevention programs currently in use.

Physical Health Research

- Adolescent height and weights, intake of fat and calories, nature of and the amount of weekly exercise by gender, ethnicity, and income levels.
- Data on:
  - nutritional content of the school breakfast and lunch food programs;
  - nutrition information taught in health classes; and
  - the physical education credits required to complete middle/junior and senior high school.
- The availability, utilization, cost of, and effectiveness of school-based clinics.
- The availability, utilization, and cost of services for developmental disabled adolescents (in and out of state) including: rehabilitation, acute and long-term managed care, and ambulatory support.

Availability and Effectiveness of Adolescent Health Services and Programs

- The extent to which schools provide and students receive, comprehensive school health education.
- The extent to which the following positive factors exist within communities and statewide:
  - number of head start eligibles being served;
  - number of after-school programs;
  - number of parenting classes;
  - number of hotlines/crisis lines;
  - number of mental health counselors;
  - availability of recreational facilities;
  - number of safety/first-aid training programs;
  - a low student:teacher ratio;
  - number of school non-academic counselors
  - number of peer helper programs;
  - number of youth serving organizations;
  - number of adventure-based programs;
  - number of teen centers;
  - number of cultural heritage celebrations; and
  - number of teen health clinics.

> ***". . . communities intent on fashioning a comprehensive service delivery system are likely to experience the most progress . . ."***
>
> - *Education and Human Services Consortium*

Framework for Designing Adolescent Health Programs

The Economics of Prevention

This section details what soundly based research has shown to be important principles for prevention of adolescent health problems. Some of these principles involve no additional funding, but some are likely to require more funds to be devoted to prevention. In economic hard times, people with the responsibility for balancing budgets naturally find it hard to consider finding new money for prevention programs.

There is ample information to guide decisions about how to best spend prevention funds. If effective prevention programs are adequately funded, many costs of treating the health problems addressed by the program will be avoided. See appendix D for specific cost savings.

Prevention funding is simply an important social and economic investment. To the extent that visionary leaders can shift the monetary focus to prevention, we can expect an excellent return on this investment. If funds are not made available for appropriate prevention strategies, the future costs, in dollars and quality of life, will be significant.

Obstacles to Overcome

When we examine our current system of services for youth in the context of youth development, we find that it is far from optimal. With few exceptions, the needs of adolescents in Alaska are not effectively addressed at the local, state, or national level. Despite good intentions, programs generally fall far short of their aim. This is certainly not a problem unique to Alaska. At the national level, the Education and Human Services Consortium identified five main reasons for what they describe as the failure of our current system.[2, 10]

1. **Most services are crisis-oriented.** Because programs are designed to react to problems rather than to prevent difficulties from developing, problems multiply and become more difficult and expensive to resolve.

2. **Problems of children and families are divided into rigid and distinct categories that do not reflect their interrelated causes and solutions.** There are dozens of agencies and programs, each with its own particular focus, source of funding, guidelines, and accountability requirements. Services are provided within rather than across service categories. As a result, providers tend to concentrate on a single solution to a specific problem rather than working together toward a common goal that addresses the range of situations contributing to a family's problem or standing in the way of its resolution.

3. **There is a lack of functional communication among the numerous agencies in the health and social welfare system.** Agencies seldom see each other as allies. Rivalry often occurs when they must compete for scarce resources. There is little opportunity to draw on services available throughout the community that might complement their own. Critical difficulties in meeting clients' needs are left unaddressed, and gaps in services remain.

4. **Specialized agencies are unable to craft comprehensive solutions to complex problems.** In any given agency, there is often a lack of professional talent and expertise necessary to plan, finance, and implement the multiple services characteristic of successful interventions.

5. **Existing services are insufficiently funded.** In virtually all areas, our current system provides insufficient prevention, support, and treatment services to make a lasting difference for young people who must overcome multiple problems and years of neglect. There is a pressing need for a vastly expanded national investment in our children and families.

There are many historical and cultural factors that may explain why our system evolved with these flaws. Despite how it happened, it is important to look for ways to remedy the **system's** problems in order to protect and enhance the health of our youth. The literature about adolescent health problems and solutions is filled with recommendations to direct remedial efforts toward institutions rather than toward individuals.

Critical Elements of Successful Programs

This section is the foundation of the adolescent health plan. It is the cornerstone upon which the rest of the strategies and recommendations rest. If the concepts described in this section are not understood and applied, the usefulness of the rest of the plan may be greatly diminished.

An extensive literature review about the effectiveness of programs designed to improve adolescent health provides us with a solid idea of the components necessary for success.* Any program's potential for achieving real improvement in any area of health for any adolescent population will be enhanced to the degree that the elements described in this section are in place.

Critical Program Elements

1. Local decision making;
2. Collaborative, multiagency approach;
3. Qualified, trained, caring staff who can be trusted by teens;
4. Involvement of parents;
5. Charismatic leader(s);
6. Evaluation and program modification;
7. Risk and protective factors emphasis;
8. Programs planned according to age, gender, and culture;
9. Strong link between community programs and schools;
10. Programs are linked to "world of work";
11. Sustained efforts—No "one-shot" programs;
12. Accessibility and Affordability of services;
13. Early identification and intervention of youth-at-risk;
14. Intensive individual attention for those most in need;
15. Social skills training (information alone does not change behavior);
16. Youth actively involved in planning, implementation and evaluation; and
17. Peer education and/or peer helping incorporated into programs/services.

These elements are described more fully below.

1. Local decision making.[2, 3, 5, 9] As stated in "Code Blue," "All the federal and state aid in the world will not be enough if it is not designed to build the capacity of communities to solve their own problems." This notion has profound implications for program funding

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* Much of this section is adapted from Adolescents at Risk by Joy Dryfoos, pp. 227-43. For the most complete discussion of these concepts, readers are directed to this source.

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and other policy issues. A discussion of this follows in this section. The challenge for people at the neighborhood or community level is to organize decision making groups and to pull together the variety of resources willing and able to create change for adolescents.

2. Collaborative, multiagency approaches.[1-5] "Collaborative partnerships," as defined in "Code Blue," are "close, active working relationships in which participants share both information and decision-making. Together, they develop well-structured plans to help individual adolescents, making provisions for follow-up services and continuity. All collaborating partners share the responsibility for assuring that each adolescent and his or her family is adequately served." Schools, community health and social agencies, businesses, media, church groups, universities, police and courts, and youth groups must become partners in prevention efforts. A representative advisory group can determine the program goals and the ways that each entity is best suited to contribute.

3. Qualified, trained, caring staff who can be trusted by teens.[3, 4, 11] In almost every successful prevention program, the staff has been named as a key to success. The importance of the staff's ability to genuinely and fully "connect" with the youth they serve, and to respond to their needs with a high degree of competence and skill cannot be overstated. The programs must have leaders who are positive role models for youth! Successful intervention programs require professional staff trained as adolescent specialists. These specialists will be required in numbers rarely found in existing programs. Other programs may succeed with a greater dependence on volunteer and/or nonprofessional staff, however adequate initial and ongoing training remains an essential component.

4. Involvement of parents.[3] There are a variety of ways in which parents can be involved. Examples include: parent training and support programs (especially when done as part of home visits), use of parents as instructional aids, and participation of parents on advisory committees and school teams. Results of parent involvement with high-risk youth are not as promising as with lower-risk or non-risk groups. Getting adequate parent participation requires more than just extending an invitation for them to attend a meeting or workshop.

5. Charismatic leaders.[3, 5] In addition to staff well suited for working with youth, a leader who is charismatic and extremely competent working with youth, staff, and the broader community is a common phenomenon among successful programs. Such a leader is a powerful role model and an inspiration to all. It is difficult to know how much of a program's success is actually due to the leader's charisma and mastery, but it may be substantial. Programs would benefit by giving close attention to the qualities of successful leaders, and incorporating them into recruitment and staff training plans.

6. Evaluation and program modification. Successful programs have a well thought out plan for evaluating progress toward identified goals. Modifications in how the program is implemented are made as the need is indicated. The effectiveness of high quality prevention, support, and treatment services must be measured by the impact these interventions have on the lives of the children and families. There are inherent difficulties in measuring the degree to which an outcome has been prevented. However, indicators of success can be measured along the way, and a formative or process evaluation can provide valuable insights that can enhance the program's potential for success.

7. Risk and protective factors emphasis.[1-5] Program goals and strategies must be tied closely to the factors associated with the behaviors rather than with the behavior itself. The most successful programs take a holistic approach to adolescent health. Even programs targeting a specific problem behavior (such as teen pregnancy) incorporate holistic goals and strategies. It is impossible to change adolescent behavior with a single intervention or narrow program. High-risk behavior is strongly interrelated, and disregarding this fact will jeopardize the effectiveness of any program. This means prevention programs must be flexible and offer a "menu of services" that address a variety of needs.

8. Programs planned according to age, gender, and culture.[3, 4, 11] Age, developmental stage, gender, and culture have a tremendous impact on an individual's behavior, and interventions aimed at changing behavior must be developed accordingly. A successful program with a particular population may be quite unsuccessful with another because of inherent differences in the two populations. This does not mean that all programs should be developed around specific racial or ethnic or age group. (It could be argued that this would be detrimental if not impossible in this heterogeneous society.) However, sensitivity to the clients' age, development, gender, and ethnicity will greatly increase the program's effectiveness.

9. Strong link between community programs and schools. The interrelatedness of academic achievement and adolescents' general health behavior is extremely strong. Academic programs that are structured and carried out to maximize the learning by each child can positively affect their health. Alternative schools, service learning projects, school reorganization efforts, and dropout prevention projects can enhance teens' health status. In addition, schools are uniquely qualified to provide other, nonacademic, health-related services. Effective adolescent health programs often involve outside health or social service agencies bringing nonacademic services, staff, curricula, and technical assistance to the schools. Some examples include after-school programs, alternative schools, and school-based health centers.

10. Programs linked to the "world of work."[3, 9, 10] Youths' sense of self-efficacy, or the sense that they can effect change, is a critical prerequisite for positive health behavior. Work, including community service or service learning, is a powerful tool for empowering youth. This may include actual jobs, volunteer community service, and work exposure. Work-related skill building and career and life planning are also meaningful activities. These activities work especially well when combined with other interventions such as counseling and social skills training.

11. Sustained efforts.[3, 4] Programs that have documented success are those that exist over a sustained period. It takes time to establish high quality programs, and for the benefits to be realized. Whether the intervention is aimed at changing individual behavior or changing institutions or environments, substantial time is required. One-shot approaches are ineffective at best, and may be damaging if adolescents are left with no long-term alternatives.

12. Accessibility and affordability of services.[3, 4, 11] Lisbeth Schorr, in Within Our Reach describes this concept: "Services are coherent, easy-to-use, have continuity, are offered at times and places appropriate for youths, and are not crippled by bureaucratic obstacles." The Door, a Center for Alternatives in New York City is one model for this concept. It is a walk-in, no-fee source for help with medical care, legal consultation, drug rehabilitation, employment aid, meals, and creative aids and classes.

13. Early identification and intervention of youth-at-risk.[3, 4, 6-8] Many health problems among adolescents begin to form much earlier in life. By adequately addressing the needs of infants and young children, as well as their parents, adolescent health problems can be prevented. The earlier that threats to health can be identified and addressed, the greater the possible benefits at less overall expense.

14. Intensive individualized attention for those most in need.[3, 4, 13] Once children have been identified as at "high risk," they need to have the ongoing assistance of an adult who can be responsive to their specific needs. Personal counseling, individual tutoring and mentoring, and case management are examples of this concept.

15. Social skills training.[3, 4, 10] Youths need to understand the nature of their own risky behavior and have the skills to make healthy decisions, even amid negative influences of their peers. Successful prevention programs emphasize skills training. Information that increases knowledge without skill development is insufficient for changing behavior. Media analysis, role playing, rehearsal, and peer instruction are examples of this concept applied. The most successful programs have these types of activities at the core of the program, not just as occasional or supplementary activities. Repeat training and sustained attention to skill development is also important.

16. Youth actively involved in planning, implementation, and evaluation.[3, 4, 11] In successful programs, youths are involved in meaningful ways with nearly all aspects of the program. Their participation is sought and valued. They have responsibilities and make contributions that are closely tied to the program's outcomes. They are viewed as part of the solution, not just recipients of services.

17. Peer education and/or peer helping incorporated into programs/ services.[3, 12] Two researchers have analyzed the literature regarding the efficacy of peer involvement in prevention interventions. Bonnie Bernard uses the term "peer resource" as a characteristic of any program that uses children and youth to work with and/or help other children and youth; peer helping, peer mediation, peer leadership, and youth involvement. Her research shows that peer resource programs can positively affect individual psycho-social development as well as facilitate positive social outcomes. Dryfoos' analysis of the literature suggests that using peers in prevention interventions has produced mixed results but that several successful models exist.

Policy makers and program service providers may wish to refer to the checklist on pages 151-154 to determine how many of the critical elements described above have been incorporated into local adolescent health programs and services.

A Possible Model: Collaboration at the System Level

Dramatic changes at both the service delivery level and system level would help overcome the problems associated with our current incomplete and fragmented approach to adolescent health. How can we apply what experts and successful programs have convincingly shown to be essential for effective adolescent health programs? One model that is receiving much attention and seems very promising involves system-level collaboration among agencies. In this model, as described below, newly formed entities have the political and legal power to commit staff, facilities, and financial resources, and can alter existing policies and procedures to achieve common goals toward comprehensive service delivery. As discussed by Dryfoos and others, this model employs the formation of youth development agencies (YDA's). As described by Dryfoos:

> The purpose of the YDA approach is to enable the development of a multi-service program targeted to assist youth with educational, social, and health problems. This agency would have the capacity to assess needs, plan the necessary package of services, receive funds, allocate funds, provide technical assistance, and monitor compliance. It would be constituted to serve the youth of the community at large, not to promote the interests of any one program, and to set priorities objectively based on needs.[3]

YDA's would be governed by a local board or council with the responsibility and authority to plan and implement public and private cross-agency initiatives supporting the health and well-being of youth. The council would consist of key people from the fields of education, health, social services, juvenile justice, business, labor, parks and recreation, religious, and major charity and service organizations. Families and youth would also be represented.

According to the National Commission on the Role of the School and the Community in Improving Adolescent Health, a list of specific responsibilities of the YDA would include:

- develop short- and long-term plans for improving the health and well-being of children, youth, and families;
- set measurable goals and objectives, and establish systems to ascertain whether they are achieved;

- develop an inventory of existing services for adolescents, identify problem areas and needed services, and establish policies and programs that effectively meet service needs;

- encourage interagency collaboration and work out cooperative arrangements for public and private agencies to serve adolescents and their families;

- develop protocols for case management that designate the most appropriate agency for each adolescent, allowing for full collaboration among professional and nonprofessional personnel;

- stimulate and support neighborhood initiatives promoting adolescent health;

- provide early support for families; and

- monitor the provision of services for quality, continuity, and utilization.

The YDA model for planning and service delivery incorporates many of the critical elements of successful programs, described earlier, but the model could not be easily established at the community level without some changes at the state and federal level.[2, 3, 5]

State level changes for system-level collaboration
One possibility for state level changes to make adolescent health programs more viable is to create a state version of a local youth development agency; perhaps called a "youth development commission" (YDC). The YDC would be established within one agency or could be an independent entity, but it would have the same broad public and private representation. Its role would be to foster the development of multicomponent communitywide programs, responsive to local needs. Specifically, the state YDC would:

- distribute funds to communities through an RFP process;

- gather needs and services data on a statewide basis and perform statewide planning accordingly;

- stimulate community education about the needs of youth;

- offer conferences on effective strategies for helping youth;

- develop and publish materials and programs for practitioners;

- arrange for monitoring and evaluation; and

- help replicate effective communitywide models.

To be viable, both the state legislature and the governor would have to establish a mechanism for YDC funding that would be protected from changes in the political climate for funding.

It could be argued that setting up a statewide YDC in a timely manner that reflects the urgency of the youth problems in Alaska is impossible. Short of establishing a youth development commission at the state level, the state government could enable and cultivate the successful development of local YDA's by the following actions:

- delegate more decision-making to the local level;
- allow greater funding flexibility so that adolescents can experience continuity of care from a variety of programs;
- assign specific responsibilities and authorities to local councils regarding children, youth, and families, and establish a mechanism to determine the extent to which the responsibilities have been met;
- reduce bureaucratic barriers to local collaboration by such methods as coordinating, reporting and accounting procedures and requiring categorical programs to operate within comprehensive frameworks;
- strengthen funding of local programs, with priority going to low-income urban and rural communities;
- track the progress toward meeting adolescent health objectives; and
- form collaborative partnerships among state agencies to model effective coordination.

Alternatives to System-Level Collaboration: Other Interagency Partnerships*

Youth development agencies and a statewide youth development commission represent interagency collaboration at the system level. This is the most sophisticated and effective model for enhancing adolescent health, but it may not be feasible in many communities and, as noted above, it may not be achieved soon at the state level. The Education and Human Services Consortium defined three other forms of interagency partnerships that may be established to enhance services within the current system. These are, in order of complexity:

1. cooperation at the service delivery level;
2. cooperation at the system level; and
3. collaboration at the service delivery level.

1. Cooperation at the Service Delivery Level

In a cooperative arrangement at the service delivery level, partners help each other meet their respective organizational goals. They do so without making any substantial changes in the basic services they provide or in the rules and regulations that govern their agencies.

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* Much of this section is taken from "What it Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services." For the most thorough discussion of these concepts, readers are directed to this source.

Examples of cooperative partnerships at the service delivery level include:

- co-location of services;
- making and accepting referrals; and
- cross-training staff about services and eligibility requirements.

In this type of partnership, participants may share space, information, or referrals, but do not necessarily have common goals. The services of each agency continue to be designed, staffed, funded, and evaluated independently, with no alteration or participation from their cooperating partners. Existing services become more accessible to a given group of clients, but the quality of services is unlikely to change.

2. Cooperation at the System Level

At the system level, cooperative initiatives assess the need for more comprehensive services and recommend strategies to coordinate existing services. Because partners are not required to commit budgetary support or to make policy decisions on behalf of the organizations they represent, cooperative initiatives advocate for but do not negotiate policy.

Examples of system-level cooperation include:

- networking and information-sharing among members;
- community needs assessments and service inventories; and
- efforts to improve community awareness and support for comprehensive services.

This type of cooperation can achieve the following:

- improve communitywide awareness of existing services;
- focus attention on the need for change;
- build trust among participants;
- improve the climate for more decisive efforts later; and

(when combined with cooperative service delivery)

- improve coordination of existing services.

However, it will not ensure high quality, comprehensive service delivery because the system is still ordered around single issue, crisis-oriented services.

3. Collaboration at the Service Delivery Level

Instead of focusing on their individual agendas, collaborative partnerships establish common goals. In order to address problems that lie beyond any single agency's exclusive purview, but which concern them all, partners agree to pool resources, jointly plan, implement, and evaluate new services and procedures, and delegate individual responsibility for the outcomes of their joint efforts.[2]

Examples of this type of collaboration include joint case management and co-located services that are designed to further mutually agreed upon goals. What distinguishes collaboration from cooperation is that the various agencies share equally in the decision-making, form common goals that may be different from agency-specific goals, and are prepared to alter the structure for providing services to meet the common goals.

Summary

A great deal is known about what works and what doesn't work to bring real improvement in adolescent health. This section has offered specific program characteristics that, when understood and applied, will maximize program effectiveness. It has also offered several models for changes at the system level. Only with broad system changes can significant progress be made in improving the health of individuals, families, and communities. The challenge of change is great, but no greater that the potential rewards.

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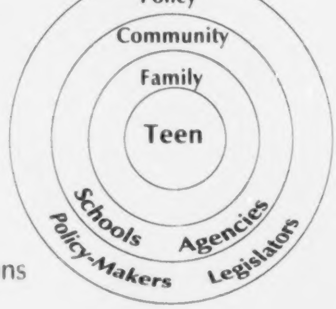
> ***“The great thing in this world is not so much where we stand as in what direction we are moving.”***
> *- Johann Wolfgang von Goethe*

Recommendations for Improving Adolescent Health

Previous sections of this document have illustrated the compelling and complex issues associated with adolescent health. However, it would be wrong to feel hopeless about our youth or the families, schools, and other agencies helping to nurture them. Indeed there are many healthy adolescents, strong families, dynamic schools, and well-functioning agencies around! We do need to acknowledge, however, that a portion of the adolescent population is struggling and suffering minor to severe health problems. It is in our best economic and social interest to effectively address these problems. We have excellent information about what to do to enhance and protect the well-being of our teenagers. This section is devoted to identifying and explaining what needs to be done.

This section may be read by itself, but it is really meant to be explored in the context of the other sections of the Adolescent Health Plan. These recommendations are based upon the assumptions and framework for thinking about adolescent health that have been described in Sections II and III. Familiarity with those sections will allow for a more sound understanding of these ideas.

The Committee used an adaptation of the Ecological Model[1] as a framework for understanding what changes need to take place. The premise of the research is that the health of our teenagers is largely determined by the lifestyle choices they make. The ability of youth to make wise decisions about their behavior—and the ability to act on those decisions—is greatly influenced by their family, the community, and public policy. These are the three groups for which the recommendations are applied.



The committee recognized five core recommendations, described below, as the heart of the solutions. These were featured so prominently in the research about successful programs, and were so integrally related to our understanding of adolescent health, that they quickly emerged as the essence of the change required.

Public Hearings

In addition to the formal research and member's own expertise, the Committee had the benefit of testimony from teens and adults throughout Alaska as another tool for preparing recommendations. In the spring of 1994 Senator Drue Pearce sponsored two teleconferences to elicit ideas about ways to improve adolescent health. One of the teleconferences was designated for youth only. A summary of the major themes of the testimony is provided in Appendix E. The recommendations in this section are consistent with the primary themes provided by the public.

Some of the recommendations may seem more practical than others. We recognize that there are constraints that make some of the recommendations not immediately employable. The Committee felt strongly that these more "visionary" recommendations serve an important purpose. If we are not willing to think beyond what can easily fit into our current model of adolescent health, we will be forever bound by its inherent limitations. As Seneca said, "When a man does not know what harbor he is making for, no wind is the right wind." We hope these recommendations offer both harbor and the right wind for all those concerned with adolescents' well-being. Now it is up to those with the boats, sails, captains, and crew to take us all where we need to go.

CORE RECOMMENDATIONS

- Provide for local decision making
- Collaborate
- Meet the needs of young children (ages 0-6)
- Focus on risk and protective factors rather than specific behaviors (such as violence, substance abuse or pregnancy)
- Follow research about what works

Provide for local decision making

Communities are best able to identify and solve their own problems. Agencies or programs largely removed from the local community can do little to directly affect the health problems of adolescents. The needs of children, youth and families can vary dramatically between communities. Communities have different strengths and resources for meeting their needs. Services and support programs should therefore be locally planned, operated and evaluated with broad public and private community involvement. The extent to which community groups exercise or have actual funding control may enhance their program effectiveness. (See page 115 for more details.)

Collaborate

The current system for addressing adolescent needs is very fragmented. Poor communication among the categorical funding agencies and their respective local program and service providers creates gaps and overlaps in the delivery of services to adolescents. Funding limitations restrict a local agency's ability to meet the range of needs experienced by troubled teens and their families. Collaborative partnerships seek to close the gaps and overlaps in service delivery by creating an efficient system of services for adolescents and families that connects service sectors, agencies and programs. (See pages 93-96, 157-158 for more details.)

Meet the needs of young children (ages 0-6)

Adolescent problem behaviors rarely develop overnight. The first few years of life are when each child receives the physical, intellectual and emotional foundation for life. Specific needs—such as physical safety, trusting relationships, a sense of autonomy—exist for each developmental phase during these years. If the needs are adequately met, the child has a strong foundation for meeting the challenges of adolescence. If the needs go unmet during the first years of life the resulting adolescent is more likely to engage in unhealthy behaviors compared to peers who received this nurturance. The "family" is uniquely qualified to provide the child or deprive the child of this solid foundation for future development.

Focus on risk and protective factors rather than specific behaviors (such as pregnancy or substance abuse)

Research has identified risk factors—conditions, attitudes or behaviors—that increase the likelihood that a child will engage in one or more problem behaviors in adolescence. Violence and delinquency, dropping out of school, substance use and teen pregnancy share several common risk factors. Research has also identified protective factors—qualities or conditions that moderate the effects of exposure to risk factors. The more we can reduce the risk factors and increase the protective factors in children's lives the more likely our children will develop into healthy, competent young adults. (See pages 11-13 and appendix B for more details.)

Risk Factors:

- Poor parent-bonding, inattentive parents, family management problems;
- Early antisocial behavior, grades K-3;
- Doing poorly in school, grades 4-6;
- Start of problem behavior at an early age;
- Low resistance to friends who engage in problem behaviors;
- Poverty; and
- History of physical or sexual abuse.

Resiliency (Protective) Factors:

- One good parent or other stable, caring adult bond;
- Supportive school atmosphere;
- Opportunities for meaningful contributions to family, school, and community;
- Start of problem behavior at an older age; and
- Resilient temperament and positive social orientation.

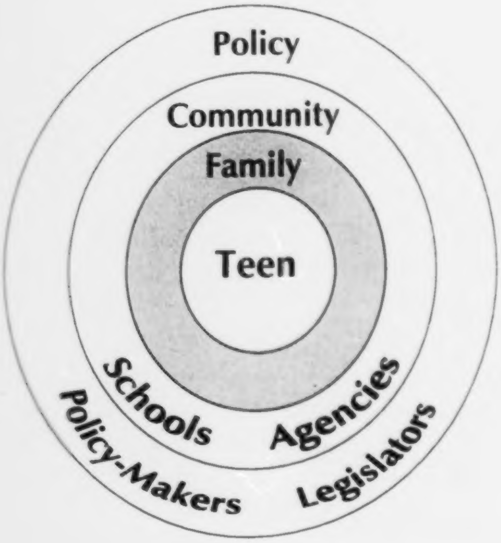
Follow research about what works

Soundly conducted research about what works for prevention of adolescent health problems gives us a solid idea of the components necessary for success. The critical elements for successful programs include:

- Local decision-making;
- Collaborative, multi-agency, approaches;
- Qualified, trained, and caring staff who can be trusted by teens;
- Involvement of parents;
- Charismatic leader(s);
- Evaluation and program modification;
- Risk and protective factor emphasis;
- Responsiveness to, and respect for, differences in culture, age, developmental stage and gender;
- Strong link between community programs and schools;
- Programs linked to the "world of work";
- Long-term efforts;
- Accessibility and affordability of services;
- Early identification and intervention for youth-at-risk;
- Intensive individual attention for those most in need;
- Social skills training;
- Youth actively involved in planning, implementation and evaluation of the program; and
- Peer education and/or peer helping incorporated into programs or services.

See pages 89-92 and 151-154 for further discussion of the critical elements.

The following pages offer a more detailed explanation of these recommendations and how they might be implemented by the different entities that will need to act on them.


Policy
Community
Family
Teen
Schools
Agencies
Policy-Makers
Legislators

"The job of parenting is simply not valued enough, in spite of the fact that the well-being of future generations depends on it."

- *Aletha J. Solter*

Family

There is no greater influence on the health of an adolescent than the family. It is the family that is uniquely qualified to nurture a child's well-being. From the very beginning families either build healthy perceptions in their children or unintentionally destroy those perceptions. The quality of love and care that a child receives in the first years of life is the major factor determining that child's ability to think, grow, and love.

Throughout history, family units have taken on a variety of forms including foster families, single parent homes, and multi-generational living. Though the forms may vary, the function remains the same: providing nurturance, encouragement, positive role-modeling, guidance, protection, open communication, negotiated limits, and consistent expression of values.

Many Alaskan families are to be commended for their positive influence. Measures must be designed, however, to strengthen troubled families. Today's fast-paced, high-stress, highly-transient society often makes it difficult for families to provide the nurturance and protection necessary for their children. The following pages illustrate how the Committee's core recommendations could apply to affirm, strengthen, and empower the families of Alaska.

Provide for local decision making

Participate in a community assessment and planning process to address adolescent health problems. (See page 115 for details.)

Join with other families to communicate to the local schools reasons to make school facilities more family-friendly. Bring to the forefront issues such as child care and the need for extracurricular activities before and after school. (Such expanded services for families in need would not be expected to come out of existing budgets or be provided by current school staff.)

Collaborate

Join with other families to provide emotional and physical support to families in need.

Volunteer time and expertise to local or statewide agencies.

Unite with other families to provide clubs, sports, special events, cultural activities, and opportunities for meaningful work for the youth of your community.

Meet the needs of young children (ages 0 - 6)

Recognizing the value of quality and quantity time during the formative years, create emotional bonding opportunities through shared time and activities.

Recognizing the critical nature of the developmental years, opportunities should be provided which develop each child's learning capacity. During the first three to four years of life, "Paying attention and concentrating, trusting and relating to others, controlling impulses and actions, being imaginative and creative, distinguishing fantasy from reality, and having positive self-esteem is either learned or not learned."[2]

Seeking to contribute positively toward a child's sense of being capable, significant, and influential, families can instill healthy self-perceptions by checking for understanding, exploring experiences, encouraging, celebrating progress, and respecting each child.[3]

When both (or single) parents must work outside the home, they should carefully select a child-care provider. Families "are not simply buying a service that allows them to work. They are buying an environment that determines, in large part, the development of their children."[4]

Focus on risk and protective factors rather than specific behaviors

(See appendix page B-ii for details.)

Because a caring, supportive relationship remains the most critical variable throughout childhood and adolescence, a high priority should be relationship-building through shared meaningful activities and communication.

Recognizing that children learn very little from what we say and almost everything from what we do, we must model desired behavior.

Understanding that problems are generally opportunities for growth, look for teachable moments. Provide support and advice when the child is ready to receive it.

Follow research about what works

Because child-raising strategies sometimes become trendy, families should follow current research and seek the experienced wisdom of adults who have had successful parenting experiences.

Knowing that issues and capabilities vary with each age and developmental phase, it is important to learn to respond to children in an age- and developmentally-appropriate way.

Research has identified doing poorly in school in grades 4-6, and having a low commitment to school as predictors of future adolescent problem behaviors. Become involved in your children's school and in their learning. There are many ways parents can be involved in their childrens education. The Search Institute offers the following ideas:[5]

- Take advantage of conferences and other chances to talk with teachers and other staff.
- If you suspect there may be problems, don't wait for the school to call; check in when you don't hear from them.

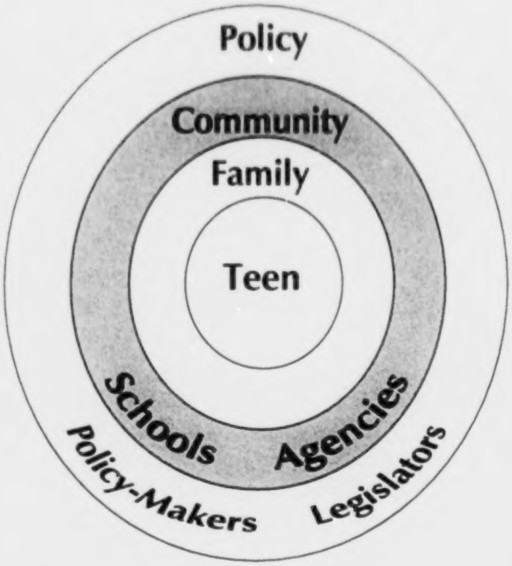
- Create and protect time and space for homework.
- Offer to be a resource in your areas of expertise for your child's teacher.
- Ask your children daily about what happened in school; talk about issues, concerns, and needs.
- Participate in parent-teacher organizations or other advocacy groups.
- Encourage the development of a parent resource center in the school. Look for and recommend parenting books for the school to lend to parents.

Family Programs

The following family-based, health program approaches have been researched and found to be effective. Each community will need to determine the appropriate programs for their population. (See pages 159-167 for detailed descriptions.)

- Preschool and Head Start-type programs
- Home visiting programs
- Parent training/support programs*

* *Promising approaches without rigorous evaluation.*


Policy
Community
Family
Teen
Schools
Agencies
Policy-Makers
Legislators

"What its children become, that will the community become."
- *Suzanne Lafollette*

Community Level

- Neighborhoods and Communities
- Schools
- Local Agencies and Community Organizations

The community can play a significant role in promoting the health of adolescents by helping to provide a safe and healthy environment for families to raise their children. In addition, it can assure that programs and services focus on primary prevention by addressing risk and protective factors associated with adolescent behaviors, early intervention, and strengthening the ability of children, youth, and families to help themselves. Adolescents with multiple problems need support and assistance in a variety of contexts. Addressing education or behavior problems without attending to family or health problems is seldom effective.

Parts of the community can have a very positive influence on adolescents from troubled backgrounds. Meaningful work, service-learning opportunities, a strong sense of cultural or neighborhood pride, strong spiritual beliefs, or a significant person in the teen's life can make up for earlier deficits. The more a young person feels a connection or bond to its community or neighborhood, the less likely he/she will engage in antisocial behaviors.

> ***"We criticize and separate ourselves from the process. We've got to jump right in there with both feet."***
> - Delores Huerta

Neighborhoods and Communities

Provide for local decision making

Commit, as a community, to a comprehensive planning process to assure services for children, adolescents, and their families are based upon:

- documented needs;
- filling program and service gaps; and
- drawing from community strengths and available resources.

Programs and services must be locally planned, operated and evaluated with broad public and private community involvement. The extent to which local groups have actual funding control may enhance their program's effectiveness.

Volunteer your time and talents to the community planning process. The basic steps in this planning process include: Mobilizing a core group with which to collaborate, collecting and organizing data, identifying health priorities, developing and carrying out comprehensive strategies, and evaluating those efforts. (See "Community Planning Process" on page 115.)

Communicate with other Alaska communities to locate additional successful strategies. Contact the Adolescent Health Coordinator, Division of Public Health for detailed program information.

Community Planning Process

Local decision making requires the community to make a long-term commitment to address the health and well-being of its children, adolescents, and families. The community must join together to identify its problems and decide how best to solve them. This effort is called the community planning process. All segments of the population must be engaged to insure diverse perspectives are considered. If a planning group already exists, advocate adding adolescent health to its mission statement. The basic steps in community planning are provided below. (See pages 169-190 for a detailed description of this process.)

1. Mobilize a group of people who are willing to make a long-term commitment to creating a healthier environment for children and adolescents. The group should represent all sectors of the community, such as health providers, school, parents, local agencies, teens, and businesses.

2. Collect and organize data. For a community to understand their problems and the underlying factors affecting those problems, information must be collected at the local level. The local health assessment may be used to identify community needs. It can determine the overlap and gaps in services and programs for children, adolescents, and their families. Data collection and analysis takes time! A minimum of six months is needed.

3. Chose priorities based on the local health assessment. Most communities do not have the resources to address all of their health problems and target groups at once. They must set priorities and plan to address some problems initially and others later.

4. Develop a comprehensive plan of specific strategies to address adolescent problem behaviors and their associated risk and resiliency factors. A comprehensive plan includes: 1) using multiple researched strategies (such as educational, policy and environmental) within multiple settings; 2) employing the critical elements of successful programs in the planning process; 3) addressing the risk and resiliency factors that contribute to health problems; and 4) ensuring that youth are part of the planning process.

5. Evaluate. Evaluation is an ongoing process that serves two major purposes: to monitor and assess progress during the five phases of community organizing and to evaluate the selected strategies.

Example: The Planned Approach to Community Health (PATCH) program in Hoonah illustrates the merits of community-based health planning. Members identified their health priorities *after* nine months of collecting and analyzing local data. Lack of exercise, substance abuse, and teen sexuality issues were among the top priorities. A wellness center was established to address the need for greater physical fitness in the community. Classes offered at the center have included: smoking cessation, low fat cooking, and CPR/first aid in addition to exercise and open recreation. Literally hundreds of pounds have been lost by those who came to the center. As one participant noted, "positive change is possible!"

Collaborate

Encourage community organizations and service providers to collaborate efforts to address the needs of children, adolescents, and their families. Developing a comprehensive system of services requires input and coordination from community members across service sectors, agencies, and programs. The goal is to provide a full spectrum of effective and high-quality services that sustain children, youth, and their families.

Consider forming a Youth Development Agency (YDA) to develop a community-wide, integrated approach to assisting youth with educational, social, and health problems. The purpose of the agency is to advocate for the youth of the community NOT to promote a specific categorical program. (See page 127 for details.)

Foster a sense of community pride through activities and programs such as cultural celebrations, neighborhood watch programs, support groups and community centers.

Provide neighborhood and school settings with supervised before- and after-school activities for youth. Encourage participation of children in organized groups.

Meet the needs of young children (ages 0-6)

Initiate or support efforts the community undertakes to support families as they strive to meet the physical, intellectual, and emotional needs of their children during these critical years. Consider ways to ensure that affordable child care is available for working families.

Focus on risk and protective factors rather than specific behaviors

(See appendix B-iii for details.)

Examine community norms of acceptable behavior to determine the effects they may have on increasing or decreasing the risk factors common to adolescent problem behaviors.

Review public policies to identify the mixed messages being given to youth. Establish policies to minimize risk factors and maximize protective factors in the community. (See pages 186-187 for further details.)

Involve youth in the decision making about community activities that impact them.

Hold teen "focus groups," teen panels, or add teens to community advisory groups to gain their perspective.

Volunteer your time to determine the prevalence of risk and protective factors in your community. (This is part of the community planning process—data collection stage. See pages 179-187 for details.)

Encourage service providers to place greater emphasis on addressing common risk factors for adolescent problem behaviors in local programs and services. Focus programs and community practices to build upon existing or potential protective factors in the community.

Provide opportunities for youth to participate in meaningful activities and work experiences in the community. Activities may include: repairing buildings, working with elders, tutoring younger children, conducting surveys, community beautification and natural resources projects, helping with office work, and subsistence activities. Set an example of community involvement to which youth can aspire.

Follow research about what works

Review all organized activities and youth programs to determine ways to incorporate all of the "Critical Elements of Successful Programs" into the community efforts. (See pages 89-92 and 151-154 for details.)

Stay informed of soundly conducted research on effective adolescent health strategies. Contact the Adolescent Health Coordinator, Division of Public Health for current program information.

Community Programs

The following community-based program approaches have been researched and found to be effective in increasing positive behavioral health outcomes in adolescents. Each community will need to determine the appropriate programs for their population. (See pages 159-167 for detailed descriptions.)

- Preschool and Head Start-type programs
- Parent training/support programs*
- Home visiting programs
- Peer programs
- Youth-adult mentoring programs*
- Youth service/service-learning programs*
- Health centers targeting youth from lower socioeconomic areas*

* *Promising approaches without rigorous evaluation.*

> ***"We must realize that these are all of our concerns. These are not parents' problems, kids' problems, or the schools' problems. They are everyone's concerns . . ."***
>
> *- Educational Human Services Consortium*

Schools

Provide for local decision making

Strengthen the school-community bond by being an active participant in the comprehensive community planning process and its organized efforts to address the common risk and protective factors affecting adolescent problem behaviors. (See pages 115 for details.)

To broaden the array of services offered by the school itself, explore ways of sharing costs and staffing with public and private community organizations to allow them access to the school facilities when school is not is session. Examples may include supervision of youth during non-school hours, recreation, support groups, arts and technology classes, culture and student club activities, and service-learning opportunities.

Collaborate

Establish a school-wide program to integrate the health messages children and youth receive throughout the day, not just during health education segments. (See Comprehensive School Health on page 123 for details.)

Consider the development of a parent resource center in the schools, staffed by volunteer parents.

Seek ways to link students with community-based programs geared toward youth.

Pursue oppportunities to offer health related services in collaboration with other agencies with common goals.

Examples: **Juneau-Douglas School-Based Health Center**

The Juneau-Douglas School-Based Health Center is a unique coalition of four agencies. The school district, a native health corporation, state and local governments share a common mission and provide either personal or fiscal resources for the operation of the center. The process of gathering community input regarding teen health issues and gaining necessary community support for the Teen Health Center took almost two years and involved individuals from all segments of the community.

An Advisory Board of parents, teens, agency, school, and other community representatives directs the operation of the center. Parents are requested to sign specific consent forms at the time their teenager is enrolled at the high school. The center's holistic approach includes physical health, health promotion, and a mental health component. In the first year, student services used were 37% mental health, 19% physical exams, 17% diagnosis, and 14% prevention services for pregnancy and sexually transmitted diseases.

Mat-Su Alternative School

The Mat-Su Alternative School is an excellent example of local agencies and the school district working together to provide very needed services for students who are at extreme risk of dropping out. (See page 125 for details.)

Meet the needs of young children (ages 0-6)

Collaborate with parents and relevant agencies to establish and/or maintain educational programs for children ages 3 to 4, based on a developmentally appropriate assessment of their needs.

Provide access to the school (when classes are not in session) to groups that offer services and activities for families of young children.

Organize and conduct services for preschool-aged children which collaborate with the family and agencies such as Head Start to provide a smooth transition to the school environment. Support activities designed to insure that all children enter school with high expectations for academic success.

Focus on risk and protective factors rather than specific behaviors

(See appendix pages B-iv for details.)

Facilitate the joint efforts of staff, parents, and other agencies to assure that appropriate services are provided to students showing early warning signs of behavioral problems before their school performance deteriortates. Conduct disorders and antisocial behaviors in grades K-3 have been shown to be a significant risk factor for problems in the adolescent years.

Create and/or maintain a solid educational partnership between school and parents by making parent involvement in schools a priority. The following ideas are offered by the Search Institute:[5]

- Send parents tip sheets on developmental issues and needs for their student's age.
- Invite parents to visit the school at any time; assess policies to ensure that parents feel welcome.
- Provide homework assignments that involve parents or other family members.
- Communicate with parents the expectations and opportunities to enhance learning.
- Develop advisory committees or other roles that can give parents a more active voice.
- Recognize parent volunteers in school newsletters or newspapers.

Because early school failure, low commitment to school, and early conduct disorders are predictors for future adolescent problems, identify and work closely with those students who are experiencing learning problems in the elementary grades. Aggressively pursue reform efforts designed to prevent school failure.

In order to keep *secondary* students who are failing in the traditional classroom setting from dropping out of school, provide alternative learning environments with easy access to the needed social services.

Follow research about what works

Identify causal factors behind students failing in school and ultimately dropping out. Pursue research-based ideas for changing the school setting to prevent academic failure and drop out.

Consider including peer education as an instructional strategy in grades K-12.

Work with school staff and interested community members to stay informed of soundly conducted research about ways to increase academic success. Initiate changes in local schools based on the research. For example, assess your school's structure, setting, and schedule to insure that younger adolescent's developmental needs are being met.

Review programs to determine ways to incorporate all of the "Critical Elements of Successful Programs." (See pages 89-92 and 151-154 for details.)

School Programs

The following school-based program approaches have been researched and found to be effective in increasing positive behavioral health outcomes in adolescents. Each community will need to determine the appropriate programs for their population. (See pages 159-167 for detailed descriptions.)

- Peer programs
- Youth service/service learning programs*
- Student assistance programs*
- Youth-adult mentoring programs*
- School-based health centers targeting youth from lower socioeconomic areas*

* *Promising approaches without rigorous evaluation.*

Comprehensive School Health

Children learn more effectively when their surroundings—people and the environment—give them consistent messages. When different components give conflicting messages, children and adults are quick to recognize the lack of commitment. Comprehensive school health programs are planned, purposeful integration of elements within the school to give coordinated health messages.

A school generally contains a number of components that can give or reinforce healthy messages to children. Typical components include:

Health Education—Classroom lessons that teach healthy information and give students opportunities to practice the skills they will use to apply that information to healthy decisions.

Physical Education—A planned program of information and practice that helps students achieve a fit, flexible, and strong body.

Health Services—School nurses or other health professionals provide preventative screening, information, and primary level treatment needed by growing and active children.

Counseling—School counselors and social workers help children learn coping skills, develop future plans, and intervene with children in crisis and make appropriate referrals when needed.

Food Service—School lunches and/or breakfasts provide healthy meals to fuel children's alert attention and growing bodies, and can provide models of healthy and tasty nutrition.

School Environment—School environment is the encompassing broad area of issues that comprise the "student-friendly" climate of the school, ranging from the policies assuring student's physical safety from other's aggression, to those governing how students and adults treat each other, to policies and procedures that assure that the facility is supportive of learning.

Work Site Health Promotion Programs—These programs are helpful ways for schools to provide regular models of many healthy practices for both school staff and children, and usually reduce stress, absentee-ism and health care costs as well.

School-Community Integration—For schools to succeed in any of their goals, they must have strong, ongoing ownership and involvement by parents and other community members. Positive, pro-child attitudes and practices that are consistent among schools and their communities are essential for the modeling of healthy lifestyles for children.

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"Things which matter most must never be at the mercy of things that matter least."
- Johann Wolfgang von Goethe

Local Agencies and Community Organizations

Provide for local decision making

Initiate or join in a long-term community planning process to address the needs of children, adolescents and their families. Local decision making requires the community—service providers, youth, parents, educators, community, business, and religious leaders—to come together to identify the community's problems and decide what it wants to do about them. (See page 115 for more details.)

Commit to the community planning process by deciding which pieces of this effort your agency can best contribute to:

- Collect and analyze data;
- Choose community priorities based on local data;
- Develop a community plan of specific strategies; and
- Evaluate strategies selected

Note: If the community has already established a comprehensive planning group, join forces and advocate for adding adolescent health to the mission statement.

Communicate with other Alaska communities to locate additional community-based adolescent health strategies. Contact the Adolescent Health Coordinator, Division of Public Health for detailed program information.

Collaborate

Initiate or join a coalition of service providers to develop a comprehensive system of services for youth and their families that extends across service sectors, agencies, and programs. Comprehensive services cannot be effectively delivered in a piecemeal fashion. A collaborative effort is required to connect the fragments of the current delivery system.

Establish common goals with other service providers that go beyond the categorical problems or agendas of any one agency. Agree to pool resources, jointly plan, implement, and evaluate services and procedures. Delegate individual responsibility for the outcomes of joint efforts.

Work toward collaborative, not merely cooperative, relationships with other service agencies. What distinguishes collaboration from cooperation is that the various agencies share equally in the decision-making. Participating agencies are prepared to change how services are delivered to meet commonly agreed upon goals. Genuine collaborative relationships go beyond the traditional Memorandums Of Agreements between agencies. These activities include: joint case management of high risk families and adolescents, organizing community wide prevention efforts, and co-location of services and programs.

Examples: **Mat-Su Alternative School**

The Mat-Su Alternative School is an excellent example of local agencies and the school district working together to provide very needed services for students who are at extreme risk of dropping out. Life skill classes are required while students work toward their high school diplomas or GEDs. Several support groups are held weekly and facilitated by local agencies. To prepare teenagers for a realistic career path, Job Service and JTPA help train and place students in jobs. Parenting classes are provided by the local women's resource center and the Division of Family and Youth Services (DFYS). In addition, a day care center is located on-site and staffed primarily by the students themselves.

United Way of Anchorage

United Way of Anchorage purchased a building as a long-term solution to office space needs and to reduce overhead expenses. The building is large enough to house eight of its member non-profit service agencies. By sharing rent, utilities, phone lines and maintenance, the rental costs are one-third the current market rate. The co-location of services has also allowed for the sharing a large conference room, phone system, a color copier and on-line services on the internet in the future.

Involve community members and youth in all aspects of your agency's youth programs and services; from the planning phases through implementation and evaluation. When planning specific strategies, consider community-wide, multi-pronged, and long-term efforts to address adolescent issues. Research has demonstrated this approach to be more effective than fragmented one shot, short-term efforts.

Consider forming a Youth Development Agency (YDA) to develop a community-wide integrated approach to assisting youth with educational, social, and health problems. A YDA not only brings community members together to identify needs and plan the necessary services, it can receive and allocate funds, provide technical assistance and monitor compliance. (See pages 93 and 127 for details.)

Meet the needs of young children (ages 0-6)

Develop family support services to promote healthy parenting skills to meet the intellectual, emotional, and physical needs of children during these critical years. If necessary, give priority to at-risk families and children.

Focus on risk and protective factors rather than specific behaviors

(See appendix page B-iii for details.)

Direct programs and services to target known risk factors for adolescent problem behavior. Focus programs to build upon existing or potential protective factors in the community. Coordinate your efforts with those of other programs to close service gaps.

Provide opportunities for youth to participate in meaningful activities and work experiences in your agency. For example, identify a staff member to work closely with youth volunteers in a mentorship capacity; design work experiences to build pre-employment skills; and/or provide young workers with feedback and recognition as appropriate.

YOUTH DEVELOPMENT COUNCIL

A Key to Community Initiatives
A Local Coordinating Council Model

What is a youth development council?

A youth development council is an alliance of school and public health officials, private service providers, elected officials, civic, business, and religious leaders, families, and youth. The alliance is recognized by the State as responsible for planning and implementing public and private cross-agency initiatives supporting the health and well being of children, youth and families.

Who should serve on a coordinating council?

All key public and private youth-serving agencies should be represented on the coordinating council. These include education, health, social services, juvenile justice, business, labor, parks and recreation, religious, and major charity and service organizations. Families and young people must also be represented.

What should be the responsibilities of a council regarding adolescent health?

- Develop short- and long-term plans for improving the health and well-being of children, youth, and families;
- Set measurable goals and objectives, and establish systems to ascertain whether they are achieved;
- Develop an inventory of existing services for adolescents, identify problem areas and needed services, and establish policies and programs that effectively meet service needs;
- Encourage inter-agency collaboration and work out cooperative arrangements for public and private agencies to serve adolescents and their families;
- Develop protocols for case management that designate the most appropriate agency for each adolescent, allowing for full collaboration among professional and nonprofessional personnel;
- Stimulate and support neighborhood initiatives promoting adolescent health;
- Provide early support for families in trouble; and
- Monitor the provision of services for quality, continuity, and utilization.

To whom is the Youth Development Council accountable?

The council should be accountable to the local organization or district designated by the state as the fiscal agent for state funds supporting coordinating council activities. This could be the local political jurisdiction, the local school district, the public health district, or another special purpose district.

Adapted from *Code Blue: Uniting for Healthier Youth*. The National Commission of the Role of the School and the Community in Improving Adolescent Health, 1989.

Follow research about what works

Modify your agency's youth programs and services to incorporate the "Critical Elements of Successful Programs" on a continual basis. (See pages 151-154 for details.)

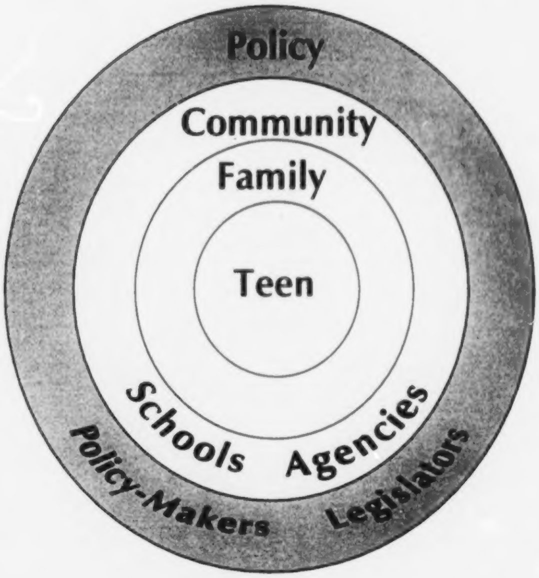
Stay informed of soundly conducted research on how to effectively improve adolescent and youth health. Contact the Adolescent Health Coordinator, Division of Public Health for current program information.

Local Agency Programs

The following types of agency-based program approaches have been researched and found to be effective in increasing positive behavioral health outcomes in adolescents. Each community will need to determine the appropriate programs for their population. (See pages 159-157 for detailed descriptions.)

- Preschool and Head Start-type programs
- Home visiting programs
- Peer programs
- Youth service/service learning programs*
- Youth-adult mentoring programs*
- School-based health centers targeting youth from lower socioeconomic areas*

* *Promising approaches without rigorous evaluation.*


Policy
Community
Family
Teen
Schools
Agencies
Policy-Makers
Legislators

> ***"Prevention is generally cheaper and more effective than crisis intervention and remediation."***
> *- Children's Defense Fund, p.7*

> ***"You do not wait until winter time to start drying fish."***
> *- Keqqulluk*

Policy Level

- **Policy Makers and State Program Directors**
- **Legislators**

Policy makers and legislators have a crucial role to play in improving adolescent health. Without change at the policy level, communities cannot carry out collaborative prevention as outlined in the core recommendations. The changes that need to be made involve allowing agencies more flexibility to carry out locally collaborated efforts, backing up these efforts with the technical assistance and tools that communities will need, and making child and adolescent health a priority in state government.

Mobilize and collaborate

Model collaboration that supports community efforts. Collaboration should be a priority at all levels of government.

Survey current statutes or regulations that inhibit collaboration. Move from categorical funding to a more flexible system, so that communities can target resources to the service gaps. Use the "Critical Elements of Successful Programs" as criteria for judging grant proposals. (See pages 151-154 for details.)

Create an interdepartmental work group consisting of mid-level managers to keep Alaska's efforts to improve adolescent health focused and coordinated. A core group of policy makers must be committed to the recommendations if they are to be carried out.

Collect and organize data

Decide upon consistent definitions for data collection. Create a clearinghouse where data may be shared between programs and departments.

Inventory all of the programs and services for children, adolescents, and their families run by state departments. Meeting the range of needs cannot be achieved until the State knows the current gaps and overlaps in service delivery.

Conduct a statewide survey of adolescent health behaviors on a regular basis. The instrument must be similar to national surveys to insure comparability between adolescent populations.

Emphasize long-term prevention

Make long-term prevention strategies for adolescents a priority, including a greater focus on the needs of 0 to 6 year olds. If children's physical, emotional, and intellectual needs are not met during these critical years, they are more at risk for developing problem behaviors during adolescence.

Remove barriers to effective programs and services

Identify and analyze state and federal statutes or regulations that create barriers to the decentralization of adolescent health programs and services to the local or regional level. This will enable community services and programs to work more closely and thus more effectively meet the needs of children and adolescents.

Evaluate

Develop a consistent evaluation procedure, so that programs and services know what kind of progress they are making and meaningful comparisons may be made. Fund research projects to determine which programs unique to Alaska are effective in achieving behavior change.

Consider adolescents' needs in health care reform

When designing health care reform, keep the distinct needs of youth in mind. There are several key factors in health care that greatly impact youth. (See pages 140-141 for further details.)

> ***"Problems are only opportunities in work clothes."***
>
> - Henry J. Kaiser

Policy Makers and State Program Directors

Mobilize and collaborate

Provide incentives that encourage collaboration among public, private, and community agencies. External incentives are often needed to give communities the needed resources, tools and focus that will help their various service systems begin to build sustainable collaborative structures. These could be waivers that remove barriers to collaboration and/or grants to support collaborative initiatives.[6]

Create an interdepartmental work group for adolescent health in state government. The work group should conduct strategic planning and coordination of appropriate state departments to support a comprehensive, quality continuum of services for adolescents. Membership should consist of mid-level managers coordinating existing services to adolescents. This work group must have a formal agreement for collaboration with the Alaska Interdepartmental Committee for Young Children and the State Adolescent Health Advisory Committee.

Examples: **Alaska Youth Initiative**

To prevent out-of-state placement for the most severely emotionally disturbed youth, the Alaska Youth Initiative (AYI) was established. AYI provides wraparound individualized services for these youth by utilizing a team approach. Parents, counselors, teachers, and Division of Family and Youth Services work together to tailor services specific to the young person's needs. As a result, the young person is treated in their own environment according to their needs and cost savings are realized by the State.

Alaska Interdepartmental Committee for Young Children
Five departments within state government provide a variety of programs and services for young children and their families. To avoid gaps in services and duplication of efforts, program managers began holding information-sharing meetings over ten years ago. This effort evolved into joint strategic planning and coordination by the member agencies. Thus, the Alaska Interdepartmental Committee for Young Children was created through formal agreements between the five departments. The purpose of AICYC is to support a comprehensive, quality system of services for young children (0-8) and their families. The committee coordinates in the following areas: policy development, program development, research and evaluation, community education/public awareness and training, and technical assistance.

Collect and organize data

Collect data in a consistent manner so that it may be shared between programs and departments.

Establish a clearinghouse of data so communities can access existing data on their community and region without having to resurvey.

Conduct a statewide anonymous survey of adolescent behaviors on a regular basis. Behaviors should include questions on sexual activity, tobacco, alcohol and other drug use, depression, delinquency, weapons use, fighting, nutrition, and physical fitness information. The instrument used must be similar to national surveys to insure comparability between adolescent populations.

Inventory services and programs for children and youth ages 0-21 and their families run by all the relevant departments in state government. Distribute this listing of state resources for children, youth, and families so a community knows where it can turn to for help in developing and augmenting its programs and services.

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Emphasize long-term prevention

(See appendix E for details.)

Increase emphasis on infant and early childhood (ages 0-6) programs.

Increase emphasis on long-term prevention efforts directed toward adolescent health. Insure that programs and services collaboratively address adolescents. Place the focus of programs on risk and protective factors *within* the community, instead of addressing the specific outcome behaviors such as substance abuse or teen pregnancy.

Emphasize the role of known risk and protective factors in scoring grant proposals. Award higher marks to programs that target youth before the problem behavior begins.

Remove barriers to effective programs and services

Change the system of funding programs and services to allow for more comprehensive and flexible service delivery on the local level. Move away from categorical funding.

Pool resources to make grant funds, technical assistance, and other ongoing support available for local communities to be able to address adolescent health through research-based strategies. Each community will need to determine the appropriate programs for their population:

- Preschool and Head Start-type programs
- Home visiting programs
- Parent training/support programs*
- Peer programs
- Student assistance programs*
- Youth-adult mentoring programs*
- Youth service/service learning programs*
- School-based or community-based health centers targeting youth from lower socioeconomic areas*

* Promising approaches without rigorous evaluation.

Establish a clearinghouse of model state and national adolescent health programs. Draw from existing national data bases which collect information on researched and evaluated adolescent health programs. This information must be available to communities as they develop, implement and evaluate local programs.

Evaluate

Develop and implement consistent evaluation criteria for youth serving programs.

Fund research projects to determine which programs unique to Alaska are effective in achieving behavior change.

Include "Critical Elements of Successful Programs" into the scoring of all grant applications. (See checklist on pages 151-154.) Use them for on-site monitoring of state funded programs.

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> ***"Common sense, fiscal responsibility, and compassion argue for policies that ensure children and families access to supports before problems occur."***
>
> *- WT Grant Foundation, Commission on Youth*

Legislators

Mobilize and Collaborate

Direct and fund a state department to create an interdepartmental work group.

Direct state departments to formulate a consistent definition of collaborative efforts. Insure collaborative efforts take place on the State and local level.

Direct state programs and services to modify funding of programs and services to allow for more comprehensive and flexible services delivery on the local level. Move away from categorical funding.

Collect and organize data

Direct state departments to improve data collection and dissemination on child and adolescent health. Part of this effort includes establishing consistent definitions so data can be meaningfully compared.

Direct a state department to establish a clearinghouse of data.

Direct the State to inventory programs and services for children, adolescents, and their families run by relevant state departments.

Direct and fund a state department to conduct a statewide anonymous survey of adolescent behaviors on a regular basis. Behaviors should include questions on tobacco, alcohol and other drug use, depression, delinquency, weapons use, fighting, sexual activity, nutrition, and physical fitness information. The instrument used must be similar to national surveys to insure comparability between adolescent populations.

Emphasize long-term prevention

Adopt a commitment to sustained prevention efforts for adolescent health and have this commitment be reflected in the budget. (See page 142 for more information.)

Direct state programs and services to:

- Increase emphasis on infant and early childhood (ages 0-6) programs.
- Insure that programs and services collaboratively address adolescent health. Place the focus of programs on risk and protective factors *within* the community, instead of on specific behaviors.

Remove barriers to effective programs and services

Direct the interdepartmental work group (or a state department) to identify and analyze any state and federal statutes or regulations that create barriers to the decentralization of adolescent health programs and services to the local or regional level.

Direct a state department to establish a clearinghouse of model adolescent health programs from around the state and nation.

Direct state departments to pool resources to make grant funds, technical assistance, and other on-going support available for local communities to address adolescent health through research-based strategies. The following program approaches have been researched and found to be effective in increasing behavioral health outcomes in adolescents. Each community will need to determine the appropriate programs for their population:

- ➢ Preschool and Head Start-type programs
- ➢ Home visiting programs
  Parent training/support programs*
- ➢ Peer programs
- ➢ School-based or community-based health centers targeting youth from lower socioeconomic areas*
- ➢ Student assistance programs*
- ➢ Youth-adult mentoring programs*
- ➢ Youth service/service learning programs*

* Promising approaches without rigorous evaluation.

(See pages 159-167 for details.)

Evaluate

Fund research projects to determine which programs unique to Alaska are effective in achieving behavior change.

Direct state programs and services to include the "Critical Elements of Successful Programs" into scoring of all grant applications. (See the checklist on pages 151-154.)

Consider adolescents' needs in health care reform

Include comprehensive health care for all children and adolescents in health care reform efforts. The distinct needs of adolescents should be considered in any health care reform effort.[7] The Society of Adolescent Medicine offers the following criteria for evaluating health care for adolescents:[8]

1. Availability: age-appropriate services and trained healthcare providers must be present in all communities.
2. Visibility: health services for adolescents must be recognizable, convenient, and should not require extensive or complex planning by adolescents or their parents.
3. Quality: a basic level of service must be provided to all youth, and adolescents should be satisfied with the care they receive.
4. Confidentiality: adolescents should be encouraged to involve their families in health decisions, but confidentiality must be assured.
5. Affordability: public and private insurance programs must provide adolescents with both preventative and other services designed to promote health behaviors and decrease morbidity and mortality.
6. Flexibility: services, providers, and delivery sites must consider the cultural ethnic and social diversity among adolescents.
7. Coordination: service providers must ensure that comprehensive services are available to adolescents.

The Cost Savings of Prevention

Prevention funding is an important social and economic investment. To the extent that visionary leaders can shift the monetary focus to prevention, we can expect an excellent return on this investment. If funds are not made available for appropriate prevention strategies, the future costs, in dollars and quality of life, will be significant. (See appendix page D-i for details.)

Societal Investments			Societal Savings
$1.00	on prenatal care	saves	$3.38 in later health costs.
$1.00	on childhood immunizations	saves	$10.00 in later medical costs.
$1.00	on food and nutrition counseling for pregnant women in the Special Supplemental Food Program for Women, Infants, and Children (WIC)	saves	$3.13 in Medicaid costs within sixty days of the infant's birth by preventing low birthweight babies.[2]
$1.00	for quality preschool education, like Head Start	saves	at least $6.00 in later special education, crime, welfare, and other costs.
$3.00	home visiting services/ child abuse prevention	saves	$6.00 in later child welfare and special education services, medical care, foster care, counseling, and housing of juvenile offenders.
$1.00	spent on a smoke detector	saves	$65.00 in later medical care, property damage and other costs.
$1.00	for comprehensive job training, education, and support services through the Job Corps	saves	$1.46 in later crime, lost tax, and other costs.
$1.00	spent on enforcing laws against serving intoxicated patrons of bars and restaurants	saves	$94.00 in later medical care, property, public services, employer, and other costs.
$1.00	spent on an intensive sobriety checkpoint program	saves	$8.00 in later medical care, public services, property damage, and other costs.

Sources: 1990 U.S. Congressional Record, Children's Defense Fund, Children's Safety Network—Economics and Insurance Resource Center, and the National Committee to Prevent Child Abuse. (See appendix page D-iv for further bibliographic information.)

References

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2. Greenspan, S. in Pransky, Jack. *Prevention: The Critical Need*. Burrell Foundation and Pardigm Press. Springfield, MO 1991: 67.

3. Glenn, Stephen and Nelson, Jane. *Raising Self-Reliant Children in a Self-Indulgent World,* Prima Publishing and Communications. Rocklin, CA 1989.

4. Pransky, Jack. *Prevention: The Critical Need*. Burrell Foundation and Pardigm Press. Springfield, MO 1991: 70.

5. Respecteen *Youth Update*. Search Institute. November, 1994.

6. *Integrating Education, Health and Human Services for Children, Youth and Families: Systems that are Community-based and School-linked.* Principles developed by more than fifty national organizations concerned with the well-being of children, youth and families. Washington D.C., January, 1994.

7. Irwin, Charles; Brindis, Claire; Holt, Katrina; and Langlykke, Kristin. ed. *Health Care Reform: Opportunites for Improving Adolescent Health*. U.S. Department of Health and Human Services, Public Health Service, Maternal and Child Health Bureau, Health Resources. 1994.

8. Society for Adolescent Medicine. "Access to Health Care for Adolescents." *Journal of Adolescent Health*. Vol 13, 1992: 162-170.

Resources to Identify Services for Children, Adolescents and their Families

This is a list of directories with current information on programs and services for children, adolescents, and their families. All these directories update their listings regularly to keep up with the changes in services offered, focus, location, and population served. Many of the directories below are available through the Alaska State Library and may be accessed through any local library.

Alaska Resource Manual

A comprehensive listing of health and human services and programs broken out into 7 regions statewide. Published bi-annually; latest edition 1994. Cost: $50.00.

ACCESS Alaska Inc.
3710 Woodland Drive Suite 900
Anchorage, AK 99517
248-4777

Programs and Services for Young Children and Their Families

A resource guide of services for children ages 0-8 provided by state agencies through the departments of Education, Community and Regional Affairs, Public Safety, Health and Social Services and Environmental Conservation and Revenue. Published 1994. Cost: none.

Head Start Coordinator
Community and Regional Development
Department of Community and Regional Affairs
Box 112100
Juneau, AK 99811
465-3861

Where to Turn

A listing of resources for families who live with someone experiencing a physical, mental or emotional disability. Published bi-annually; latest edition 1993. Cost: none.

Governor's Council on Disabilities and Special Education
Box 240249
Anchorage, AK 99524
563-5355

Alaska Health & Safety Education Resource Directory

A listing of health and safety organizations known as resources for public education information and materials. Most serve on a statewide or regional basis. Published bi-annually; latest edition 1993. Cost: $50.00.

Alaska Health Fair Inc.
Box 202587
Anchorage, AK 99520
278-0234

Answers: 1994 Anchorage Human Services and Resource Guide

A comprehensive listing of social services and programs for all ages within Anchorage. Published bi-annually; latest edition 1994. Cost: $50.00.

Anchorage Human Services and Resource Guide
514 Arthur Court
Anchorage, AK 99502
243-1076

Investing in our Children: The Child Health Planning Work Group Reports

A long-term plan, divided into an executive summary and three volumes, to address children's health needs by Department of Health and Social Services. Volume I contains the strategic plan. Volume II is comprised of summary information of child health programs, needs assessment and demographic profile, and a budgeting analysis of child health spending by DHSS. A compendium of public input makes up Volume III. Single volumes or the whole set may be ordered. Published 1994. Cost: none at this time.

Division of Administrative Services
Planning Section
PO Box 110650
Juneau, AK 99811-3015
465-3015

Healthy Alaska Information Line (800) 478-2221

A toll-free referral number that allows Alaskans across the state to locate their closest health resources. Information is accessible through phone TTY, modem and a hard copy print out. Community and regional referral information is updated every six months.

Department of Health and Social Services
Division of Public Health
Section of Maternal Child and Family Health
1231 Gambell ST.
Anchorage, AK 99501
(800) 478-2221

P.A.R.E.N.T.S.
(Parents as Resources Engaged in Networking and Training Statewide)

This resource agency provides parents with information and support in locating and networking with community agencies and resources. The organization is for families of children with any type of special need including: gifted, adopted, developmentally delayed, FAS/FAE (Fetal Alcohol Syndrome/Effect), ADD (Attention Deficit Disorder), and medically complex children.

P.A.R.E.N.T.S.
540 W. International Airport Road, Suite 200
Anchorage, AK 99518
563-2246 or (800) 478-7678

Toolbox for Communities

To help communities implement the recommendations on pages 99-142, the following "tools" are provided.

Critical Elements of Successful Programs 151
a checklist of what research has determined to be essential elements of successful programs.

Strategy and Collaboration Questionnaires 155
a questionnaire to determine which prevention strategies to use, and a questionnaire to determine the level of agency collaboration.

Program Approaches That Work 159
a description of evaluated program approaches that have been found to be effective in changing behavior.

Community Planning Process 169
a detailed description of the community planning process.

Local Health Assessment 175
a guide for collecting information on children, adolescents, and their families as part of the community planning process.

For more information contact:
Adolescent Health Coordinator; Division of Public Health, Section of Maternal Child and Family Health; 1231 Gambell Street; Anchorage, AK 99510; 279-4711.

Critical Elements of Successful Programs

Ample research* provides us with a solid idea of the program components necessary for success in improving adolescent's health and well-being. The more critical elements incorporated into a program, the higher the potential for achieving real improvement in adolescent health. The checklist on the following pages will help you determine how many of the critical elements your program or service currently uses. (See pages 89-93 for detailed descriptions of the critical elements.)

1. Local decision making;
2. Collaborative, multi-agency approach;
3. Qualified, trained, caring staff who can be trusted by teens;
4. Involvement of parents;
5. Charismatic leader(s);
6. Evaluation and program modification;
7. Risk and protective factors emphasis;
8. Programs planned according to age, gender, and culture;
9. Strong link between community programs and schools;
10. Programs linked to the "world of work";
11. Sustained efforts—No "one-shot" programs;
12. Accessibility and affordability of services;
13. Early identification and intervention of youth-at-risk;
14. Intensive individual attention for those most in need;
15. Social skills training (information alone does not change behavior);
16. Youth actively involved in planning, implementation, and evaluation; and
17. Peer education and/or peer helping incorporated into programs/services.

*Dryfoss (1990); Shorr (1988); Hechinger (1992); Bernard (1990 & 1991); Scales (1990); Pransky (1991); Johnson-Pitman (1991) Melaville and Blank (1991); and Educational Human Services Consortium (1989).

THE CRITICAL PROGRAM ELEMENTS CHECKLIST

Critical Elements	Present			Examples/Comments
	N	P	F	
1. Local decision making with lots of people's input from the beginning throughout the project				
2. Collaborative, multi-agency approach (agencies & community groups working together)				
3. Qualified, trained, caring staff who can be trusted by teens				
4. Involvement of parents				
5. Charismatic leader(s) (anasset, not a requirement)				
6. Evaluation and program modification				

KEY: N = not at all P = partially F = fully

THE CRITICAL PROGRAM ELEMENTS CHECKLIST				
Critical Elements	**Present**			**Examples/Comments**
	N	**P**	**F**	
7. Emphasize risk and protective factors, maintain a holistic focus				
8. Programs are planned and modified according to age, gender, culture, and developmental stage				
9. A strong link between community programs and schools				
10. Programs linked to the "world of work", service opportunities available				
11. No "one-shot" programs (long-term efforts must be in place for real behavior change to occur)				

KEY: N = not at all P = partially F = fully

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THE CRITICAL PROGRAM ELEMENTS CHECKLIST

Critical Elements	Present			Examples/Comments
	N	P	F	
12. Accessability and affordability of services				
13. Early idenification and intervention of youth-at-risk				
14. Intensive individual attention provided for those most in need				
15. Social skills training (information alone does not change behavior)				
16. Youth ACTIVELY involved in all stages of the program/activity (such as planning and evaluation)				
17. Peer education and/or peer helping incorporated into programs/service				

KEY: N = not at all P = partially F = fully

Strategy Questionnaire

What is the best strategy to prevent adolescent problem behaviors?

Before you decide to "adopt" or adapt a program or activity you have to decide: Will it work in my community? Is this the right combination of approaches? The following questions may help.

1. Does it address known risk factors? If so, which ones?

2. How will it reduce or eliminate these risks?

3. Are the most significant risks being addressed?

4. How will it INCREASE the protective factors?

5. Does this "program/activity" happen BEFORE the problem behavior begins or stabilizes?

6. Does it address MULTIPLE risk factors with multiple strategies in different settings?* What are the strategies and in which settings do they primarily reside (family, school, agency, community, government)?

7. Is it likely to reach those individuals/groups most at risk? How?

8. Does this activity duplicate current efforts?

*Effective programs use multiple strategies in different settings.

This questionnaire was adopted from the "Community Risk and Resource Assessment Training" of *Communities That Care,©* created by Developmental Research and Programs, Inc., a community risk-focused prevention training system.

Information on *Communities That Care©* training and materials is available from DRP, Inc., 130 Nickerson, Suite 107, Seattle, WA 98109; Phone 800-736-2630; Fax 206-286-1462.

Collaboration Questionnaire

ASSESSING THE NEED FOR INTERAGENCY PARTNERSHIPS

Agencies and communities can take the first steps toward improving outcomes for the children and families they serve by asking themselves tough questions. The following inventory is presented to stimulate reflection and to assist organizations to make the case for change. We trust that the conversations begun by these inquiries will lead to action on behalf of more comprehensive services for children and families.

I. How are we doing on our own?

1. Are the lives of the children, youth, and families we serve improving? If not, why not?
2. Have we reassessed our mission recently in light of the overlapping economic, education, health, employment and social services needs of our clients?
3. Are services to clients well integrated within our own agency?
    a. Do staff working with the same clients communicate frequently?
    b. Do staff and clients work together to set personal and family goals?
    c. Does our agency measure the impact of its services on the lives of children and families or do we simply tabulate the number of services we provide?
    d. Do we offer preventive supports and services to help our clients avoid more serious problems?
    e. Are our services organized in response to client needs or are the kinds of services we offer constrained by the limitations of available funding and administrative rules?
4. How well are we connected with other agencies offering services which our clients need?
    a. Do our line workers have effective working relationships with their counterparts in other agencies?

b. When our clients are referred elsewhere for services, are we kept informed of their progress and changing needs?

II. Do we need to change?

1. How effective will we be in ten years if the needs of our client population continue to increase and we continue to do "business as usual"?
2. What resource limitations do we face in bringing more comprehensive services to our clients?
3. How might closer relationships with other agencies help us improve outcomes for the families we serve?

III. How ready are we to engage in interagency partnerships?

1. Do the agencies serving children and families in our neighborhood, our school community, our city and our county have a common vision of what they are trying to accomplish?
2. What is the history of cooperation and collaboration in our neighborhood, community, city/county? What lessons can we learn from past experience (or lack of it)?
3. Do we have close working relationships with the directors of other agencies that deliver services to the same clients? What do we know about other agency's current needs and priorities that might encourage them to discuss common problems and potential solutions on behalf of our clients?
4. Who are the leaders from outside the direct service community who are interested in the well-being of the community and who might take a leadership role in a collaborative effort or assist with the expansion and improvement of ongoing activities?
5. What are we willing to pay in terms of tangible resources and loss of unilateral control to formulate common goals with other agencies and to better serve our shared clients?

Taken From: *What It Takes*, by Atelia I. Melaville and Martin J. Blank. Human Services Consortium, 1991.

Program Approaches That Work

Millions of dollars have been spent on social programs dealing with adolescent health problems and behaviors. Very little change is demonstrable. Most programs are small, not scientifically evaluated, and of short duration.

Communities in Alaska are advised to use their precious time and dollars on programs that have been shown to be effective in changing behavior. The Adolescent Health Advisory Committee used the following criteria to include program types in this section:

1. Controlled studies must be available. A controlled study of a program is one in which two sizable, similar groups live in the same situations, but only one group has the program experience. The outcome of both groups can be measured.
2. The behavioral change must be measurable.
3. Behavioral change must occur over time. An increase in knowledge is not enough.

In many cases it is not known precisely which parts of a program make it work or if it is all parts working together. It is known that community-wide, multi-agency, multi-component interventions work in situations where single programs seem to fail. Therefore, just borrowing a piece from a program that works may not lead to the same desired results.

Communities are urged to use the "Critical Elements of Successful Programs" in every stage of planning. (See pages 151-154 for further detail.) Contacting people who work with the following programs or the Adolescent Health Coordinator, Division of Public Health can also be very helpful during the planning process.

Preschool/Head Start-type Programs

Head Start is a comprehensive early childhood program which originated as part of the War on Poverty in 1964. Children from income eligible families participate in a program which includes parent involvement and education, developmentally appropriate early childhood education, nutrition, and health.

Evaluation: *Over the years, studies have shown that participation in Head Start increases social competency and the ability to succeed in the primary grades. Long-term studies, such as the Perry Pre-School Project, have shown that well-run early childhood programs can reduce delinquency, reduce teen pregnancy, increase employability, and increase high-school graduation rates.* [1]

Home Visiting Programs

Home Visitation provides services in the home by a professional or paraprofessional, to meet the needs of new parents or "high-risk families". A Home Visiting Program can reduce barriers to service, provide support and encouragement to families, and create a link between the family and other social and community supports. Home visitors become aware of the overall needs of the family and assist them in getting these needs met so they can effectively parent the child(ren).

Evaluation: *Evaluation showed a dramatic decrease in preterm delivery for very young teenagers, fewer families on public assistance (a decrease of one half), lower rates of repeat pregnancies and juvenile delinquency and reduced abuse and neglect of children.* [2, 24] *This approach has been endorsed by the U.S. Advisory Board on Child Abuse and Neglect and the U.S. Government Accounting Office, among others, as the single most critical element in a comprehensive approach to preventing child maltreatment.*

Peer Programs

Peer programs involve youth in the planning, implementation and/or evaluation of programs directed toward their peers of the same age or younger (usually elementary school children). Peer programs aim at enhancing the positive impact of peer groups and minimizing their potential negative impact. [5] Peer Programs have been broken down into four categories:

1. **Positive peer influence**—programs that attempt to influence young people in constructive directions, through group or individual interaction. Examples are life skills training programs,

self-esteem building programs, and teenage discussion groups.

2. **Peer teaching**—programs that use teens to convey information to their peers. Examples include peer tutoring, cross-age teaching, and teenage health consultants.

3. **Peer helping/facilitation**—programs that use teens to counsel or otherwise help their peers. Peer mediation and peer counseling are examples of this type of program.

4. **Peer participation**—programs that engage peers in decision-making and advisory relationships within the schools, outside agencies, or other systems. Examples include youth action teams and youth advisory committees.[6]

Evaluation: *A meta-analysis of 143 drug abuse prevention programs concluded that for the average adolescent, peer programs have a superior effect in reducing drug abusing behaviors compared to all other program approaches.*[7] *A World Health Organization collaborative study found that the peer-led approach to alcohol education appears to be effective across a variety of settings, economies and cultures. Students in the peer-led programs reported significantly less use of alcohol and reported fewer friends drinking at the post-test than did students in the teacher-led program or control groups.*[8] *Two peer-led AIDS education prevention programs found greater gain in knowledge, attitudes, and satisfaction than in an adult-led AIDS prevention program.*[11,12]

Promising Program Approaches

The following program types are recommended because they incorporate the "Critical Elements of Successful Programs." These programs are labeled "Promising Approaches" because the evaluations did not include control studies or are still too short-term at the time of publication to meet the criteria of behavior change over time.

Student Assistance Programs

Student assistance programs provide prevention and intervention services to those students whose lives have been impacted by alcohol and drug abuse, violence, divorce, death, child abuse or who may be coping with stress or depression. A core team, comprised of trained school staff, identifies those students in need and refers them, with parent and teacher permission, to a support/education group.

The student assistance program conducts a variety of support/education groups. Elementary school support groups may include: problem solving, self-esteem, social skills, conflict resolution, divorced families and grief groups. Secondary support groups may include: recovery support (from alcohol and drugs), concerned persons (children of alcoholic and drug using family members), grief and loss, and anger management.

Evaluation: *Evaluations based on a small sample showed that two-thirds of participants achieved higher grades and half improved their attendance. Students who were referred initially because they appeared to be depressed or had family problems made the greatest gains.*[9]

Youth Service or Service Learning Programs

Youth service or service learning programs engage young people in improving the living conditions and quality of life in their community. Teens are provided with valuable pre-employment skills as they volunteer for worthy causes through local organizations and community projects. An integral component of youth service programs is time set aside for students to reflect on what they did, what was learned, and what effect their work had on others. Examples of youth service projects include: tutoring, peer or cross-age teaching, repairing buildings, community beautification, protecting natural resources, working with elders, at homeless shelters, or with other needy people. Such programs give youth the opportunity to make meaningful contributions to their community, and gives the community the chance to see local teens in a positive light.

Evaluation: *Service learning is a key element in the highly successful Teen Outreach Program (TOP). Results of a three year study found that compared to the "control group," TOP participants had a 37% lower rate of school suspension, a 75% lower rate of school dropout, and a 43% lower rate of pregnancy.*[10]

School-based or School-linked Health Centers

School-based health centers place health care services on the school campus in predominantly poor and medically underserved neighborhoods. This health care delivery system reduces the barriers of cost, travel, concern about confidentiality, and fear of the unfamiliar. School based health centers take a holistic, integrated approach to meeting the needs of teens.

School-linked health centers provide the same services at a site *close* to the school campus.

Minor injuries and acute illness constitute most visits to school-based health centers. Providing sports physicals is a service which draws students who may be reluctant to seek out medical care. After the health center is established and a rapport is built between staff and students, a dramatic growth in student demand for emotional and mental health services is typically experienced. Reproductive health services, when offered, typically comprise less than 15% of all patient visits.[13] Nurse practitioners or physician assistants provide the bulk of medical services.

Evaluation: *Research findings demonstrate a long-term effect on school achievement, attendance, retention, dropout, and involvement with drugs. In some schools, incidence of teen pregnancies also decreased, and pregnant teens received early and appropriate health services.*[4, 25]

Youth-Adult Mentoring Programs

Mentoring programs match mature, caring adult volunteers with a young person in a one-to-one relationship which is carefully monitored, supported and supervised by professional staff. The focus may be on academic tutoring, providing a positive role model and friendship, supplying extra support and guidance, or some combination of these elements.

Evaluation: *A study sponsored by Charles Stewart Mott Foundation found significant increases in the academic, social and emotional domains among those children who participated in a year long inter-generational mentoring project.*[22] *A longitudinal study of over 600 former "little brothers" from 49 Canadian Big Brother programs found that 80% of participants had graduated from high school compared to 60% of their peers. This study also found a high correlation between the length of the matches and the number of post high school years of education acquired by the former little brothers, resulting in higher incomes 13 years later.*[23]

Parent Training

The focus of parent training courses is to improve family management skills in communication and problem solving, create clear family expectations for behavior, encourage academic progress, and to manage children's problem behaviors in positive ways.[14] There are numerous parenting courses in existence. They vary in course length, target audience, facilitation structure, materials used, and philosophical orientation. Regardless of the course, "most learning takes place during role plays, practicing the new techniques with the kids back home and receiving feedback on how it worked."[15]

Adolescents need healthy self-perceptions and life skills in order to demonstrate healthy behavior. To this end, the only parenting courses that have been shown to be effective are those which actually help parents develop in their children the following perceptions and skills:[16, 17]

Healthy Perceptions:
- Belief that one is worthwhile, competent and capable;

- Belief that one is important, needed and able to contribute in meaningful ways;
- Belief that one has influence or control over one's life; and
- Belief that one is loved, cared for and supported.

Social/Life Skills:

- Skills to control oneself from within—self discipline and control;
- Skills to communicate with others—able to listen, cooperate, negotiate, and empathize;
- Skills to live responsibly in today's world—adaptability, flexibility, and integrity; and
- Skills to make wise decisions based on moral and ethical reasoning.

There are certain principles that are taught in parenting courses that promote the above self perceptions and skills including the following:[18]

1. Begin with the child's perception, then share your own;

2. Help young people explore and analyze situations, and make plans accordingly;

3. Set reasonable limits and consequences in advance;

4. Encourage your child for little things done well;

5. Structure opportunities where children can experience either the natural rewards or the pain and consequences of their decisions; and

6. Communicate unqualified love and respect.

Evaluation: *While outcome studies of parenting courses may vary greatly, Alvy's 1987 meta-analysis of parenting programs concluded that they are "a critical strategy in preventing mental-emotional disabilities, delinquency, alcohol and drug abuse and (child) abuse and neglect."*[19] *It is important to note that parent training alone may not be sufficient to alter family management practices or improve children's behavior among families experiencing multiple problems. A combination of social skills training for youth and parent training has demonstrated successful behavioral outcome changes among families with multiple problems.*[20, 21]

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Community Planning for Children, Adolescents, and their Familie

Local decision making requires the community to make a long term commitment to address the health and well-being of its children, adolescents, and families. The community must join together to identify its problems and decide how best to solve them. This effort is called the community planning process. All segments of the population must be engaged to insure diverse perspectives are considered. Parents, schools, teens, agencies, law enforcement, health care providers, and government officials are all partners in assuring the health and well-being of its children and adolescents.

If a community has already established a planning group around another issue, advocate adding adolescent health to the mission statement instead of starting from scratch. Several community organizing models currently exist in Alaska: Community Partnerships (a federally funded substance abuse effort); PATCH (Planned Approach to Community Health), PATH (Partners in Action for Teen Health); APEX-PH (Assessment Protocol for Excellence in Public Health); and numerous local efforts not funded by grants.

The five basic steps in community planning are summarized below.

1. *Mobilize a group of people who are willing to make a long term commitment to creating a healthier environment for children and adolescents*

No one agency or person can take on the full responsibility of carrying out the steps in the planning process. A diverse group of dedicated community members are needed to commit to this ongoing process. The purpose of this group is to act as an "advisory council" to the community on youth issues. It establishes a collaborative work group to collect local health data, choose priorities based on the data, develop strategies tailored to their community, and evaluate community efforts. To be effective, the council needs a strong core of individuals to act as a steering committee. The process will run more smoothly if there is a local coordinator. Members of this advisory council may include:

- Youth service organizations and community groups;
- Public agencies serving children adolescents and families (for specific behaviors, e.g. substance abuse, violence, teen pregnancy);

- Teens;
- Primary health care providers;
- Tribal council members;
- Community leaders (public office holders/decision makers);
- Local business;
- Police VPSO or State Trooper;
- Religious community;
- Local media people (paper, radio, or TV);
- Parents and PTA members; and
- School staff and school board members.

2. *Collect and organize local data*

For a community to understand its problems and the underlying factors affecting those problems, information must be collected at the local level. A community assessment may be used to determine needs and identify the overlap and gaps in services and programs for children, adolescents, and their families. Since adolescent problem behaviors do not happen in isolation of community social norms and practices, an assessment may include a review of public policies. Data collection and analysis takes time! Committee members must be willing to make a commitment that will take at least six months.

A local assessment can answer such questions as: What are the behavior problems facing youth and how significant are they? How prevalent are the risk factors associated with the problem behaviors in the community? To what extent do protective factors exist in the community? Are families and adolescents aware of the community resources? A local needs assessment includes:

- A community profile: population statistics, causes of death, etc.;
- Behavioral data: prevalence of problem behaviors;
- Risk-focused data: prevalence of risk factors associated with the problem behaviors;
- Resiliency-focused data: prevalence of resiliency/protective factors associated with the problem behavior;
- Community opinion surveys: community perceptions of major problems; and
- Inventory of Community resources: agencies, programs, and services available to children, youth, and their families.

(See the Local Adolescent Health Assessment, page 175-189, for a detailed description of the data collection process.)

3. *Chose priorities based on the local health assessment*

Most communities do not have the resources to address all of their health problems and target groups at once. They must set priorities and plan to address some problems initially and others later. The community should select only **one** or a **limited** number of health problems to focus its resources on in a comprehensive manner. Steps in identifying the health priorities include:

- Examine local data, community opinion surveys, and focus group feedback to develop a list of health problems.
- Determine which health problems are most easily changed.
- Assess the community's readiness based on potential economic, political, legal, social, and cultural barriers.
- Identify community programs and policies already addressing the health problems.

As the community group works to set priorities it must examine its capacity to address one or more problems and agree which problem or problems to address first. In this process it should be remembered that true prevention of adolescent problem behavior begins in early childhood with enriching experiences and nurturing by family members.

4. Develop a comprehensive plan of specific strategies to address adolescent problem behaviors and their associated risk and resiliency factors

Community health planning requires a comprehensive health promotion effort and a review of the public policies. Truly comprehensive planning includes:

- Using MULTIPLE researched strategies (such as educational, policy, and environmental approaches) within MULTIPLE settings (such as the school, community, and health care facilities).
- Incorporating the "Critical Elements of Successful Programs" in planning local strategies. (See pages 151-154 for details.)
- Addressing the risk and protective factors that contribute to the health problems.
- Identifying strategies to address the problem behaviors BEFORE they stabilize or become chronic, in addition to providing remediation.
- Targeting the community at large as well as subgroups within the community.
- Employing a variety of activities to meet the target audiences' levels of readiness and characteristics.
- Insuring that strategies are appropriate by involving youth in the development of a comprehensive plan and the carrying out of identified strategies.

5. *Evaluate*

Evaluation is an integral part of community planning. It is an ongoing process that serves two major purposes: to monitor progress during the five phases of community planning, and to evaluate the selected strategies. Components of program and service evaluation include:

- Developing an evaluation prior to beginning the program, service or activity.
- Assessing the progress of the strategies as activities are conducted.
- Using the "Critical Elements of Successful Programs" to evaluate programs, services and adolescent health activities. (See pages 151-154 for details.)
- Monitoring participation among all parties.
- Identifying the effect of the planning process on the community.
- Using the results to improve the programs, services, and activities.

The basic steps to community planning were developed from the following community organizing and development models:

> Planned Approach to Community Health (PATCH) by the National Centers for Disease Control and Prevention
>
> Partners in Action for Teen Health (PATH) by the Colorado Health Department, Adolescent Health Division
>
> "Communities that Care"© by Developmental Research Programs, Inc.

Local Health Assessment

A community needs to have a thorough understanding of its problems before it can develop effective strategies to combat them. Statistics collected at the local level will give the community an accurate picture of the extent of the problems. A section is devoted to collecting information about behaviors since most adolescent deaths are a result of behavioral choices. Communities may want to know more about the underlying factors associated with adolescent problem behaviors. A section on risk and resiliency/protective factor data collection has also been included. Points to remember:

☞ Collecting statistics and information takes time! Plan at least six months. This process may look overwhelming, but once you get started it gets easier.

☞ The purpose of collecting this information is to help you decide what efforts are needed, and what effect those will have on the community and adolescent behavior in the long run.

☞ If you have questions about the data collection process, contact the Adolescent Health Coordinator with the Alaska Division of Public Health.

1. *Community profile*

Population (source: Department of Labor, Research & Analysis)

<1 1-4 5-9 10-14 15-19 20-24 25-44 45-64 65+

Number of males and females in each group
Number of Alaska Native, Whites, Blacks, Hispanic, Asian

Education (source: Department of Labor and local schools)

Percentage of Adults who have completed:

- elementary school
- high school
- technical school or 2 years of college
- 4 years or more of college

Current enrollment
- elementary school
- high school

Percentage of 19-20 year old population completing high school

Economic Profile (source: Department of Labor, Research & Analysis)

Unemployment rate
Per capita income
Percentage of households relying on subsistence activities
Families below poverty level

Leading Causes of Death by Age, Sex and Race Groups
(source: Alaska Bureau of Vital Statistics)

Injury Deaths

Intentional
- Suicides
- Homicide
- Number of intentional firearm deaths

Unintentional
- Motor vehicle deaths (car, truck, ATV, motorcycle, snowmachine)
- Drowning
- Deaths associated with alcohol/drugs
- Number of unintentional firearm deaths

Deaths as a result of Disease
- Cancer
- Diabetes
- Heart Disease
- Stroke
- All Others

2. *Behavioral data*

Most adolescent deaths, injuries, and diseases are the result of behavioral choices. Finding out the extent to which teens engage in problem behaviors is critical information for community planning. Anonymous "self-report" surveys are the easiest way to obtain behavioral data from teenagers. Questions should be worded in a similar way to national surveys so the results are comparable. Contact your school district or the Adolescent Health Coordinator with the Division of Public Health for more information.

Alcohol/Drug Tobacco Use

- Ever use of alcohol, marijuana, inhalants, or cocaine*
- Age of experimental use of tobacco, alcohol, and other drugs*
- Past month use of alcohol, marijuana, inhalants, or cocaine*
- Pattern of use (chronic use and binge drinking)*
- Drinking and driving or riding with a drinking driver*
- Tobacco use and current smoker *
- Current user of snuff or chew*

Sexual Behavior

- Ever had intercourse (age at first intercourse)*
- Intercourse in the past 3 months*
- Use of contraception*
- Number of teen births annually
- Number of teens with STDs annually

Mental Health

- Experiencing significant family or relationship stress
- Moderately and severely emotionally disturbed
- Eating disorders*
- Suicide attempts* and completions

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* Data may be obtained through your schools participation in the Youth Risk Behavior Survey (YRBS), developed by the National Centers for Disease Control and Prevention. This anonymous and voluntary "self-report" survey is conducted in the school.

Abuse, Delinquency and Violence

- Children and adolescents abused and neglected
- Households experiencing domestic violence
- "Juvenile Arrests" and arrests by category (age, sex, and race)
- Number of teens injured in a fight requiring medical treatment*
- Number of teens carrying weapons to school*

Physical Health

- Daily diet of fruit and vegetables*
- Amount of exercise (30 minutes, 3 times per week)*
- Under or overweight* (height/weight measurements)
- Presence of developmental disabilities

Education Issues

- Number/percentage of students who do not graduate from high school
- Average daily attendance of students
- Percentage of students not enrolled a full year
- Number of suspensions: alcohol/drug offenses, weapon, or violent offenses

Other

Use of Seat Belts*, Helmets* and Life Jackets (PFD)
Possession of a hand gun in the home (locked up or left out)

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* Data may be obtained through your schools participation in the Youth Risk Behavior Survey (YRBS), developed by the National Centers for Disease Control and Prevention. This anonymous and voluntary "self-report" survey is conducted in the school.

3. *Risk focused data collection*

Instead of collecting data on only the problem behaviors, it is helpful to know the prevalence of the RISK factors for those behaviors. The risk factors common for teen pregnancy, violence, substance abuse, delinquency, and dropping out are listed below. Under each risk factor is a list of potential indicators for that risk factor.

Problem Behavior Starts at an Early Age

- Age of first use (alcohol and other drugs)*
- Age of initial intercourse or sexual activity*
- Drug-related arrests for youth 14 and younger
- Violent crime arrests for youth 14 and younger
- Number/percentage of students not graduating from high school

Environmental Factors (when present creates a climate favorable for the problem behaviors at an early age)

- Public policies and social norms related to health (See pages 186-187.)
- Per capita alcohol consumption
- Babies born affected by alcohol or other drugs
- Number of adult alcohol-related arrests
- Availability of firearms, tobacco, alcohol, and other drugs
  - —number of gun dealers
  - —number of tobacco vending machines
  - —number of liquor sales outlets

Family Management Problems, Poor Bonding to Parent

- Reported child abuse and neglect cases
- Children living outside of the home
- Children living in foster homes
- Reports of runaway and homeless youth
- Reports of domestic violence
- Number of divorces
- Number of households with one parent

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* Data may be obtained through your schools participation in the Youth Risk Behavior Survey (YRBS), developed by the National Centers for Disease Control and Prevention. This anonymous and voluntary "self-report" survey is conducted in the school.

Early Anti-Social Behavior in Grades K-3 (you do not need to collect names, just the total numbers)

- Number of elementary students with disciplinary problems and referrals (for fighting, stealing, and verbal abuse towards peers and adults)

- Number of elementary students *diagnosed* with behavioral disorders or Attention Deficit Disorder

- Number of suspensions

Doing Poorly in School in Grades 4-6 (you do not need to collect names, just the total numbers)

- Academic test scores: ITBS (Iowa Tests of Basic Skills) 4th and 6th grade ITBS scores
- Number of youth retained each year for each grade
- Percentage of average daily attendance in 4th-6th grades

Friends Who Engage in High Risk Behavior

To get this information it is best to ask anonymous questions like: "How many of your friends engage in ______?"

Because of the difficulty of getting that information, the following information from the behavioral data section may be substituted.

- Percentage of teens engaging in alcohol/drug use*
- Percentage of teens engaging in intercourse*
- Rates of juveniles detention age 10-19

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* Data may be obtained through your schools participation in the Youth Risk Behavior Survey (YRBS), developed by the National Centers for Disease Control and Prevention. This anonymous and voluntary "self-report" survey is conducted in the school.

Poverty/Low Socioeconomic Status

- Percentage of families living below the poverty level (children living below the poverty level)
- Rate of unemployment
- Percentage of households headed by a single female
- Number of AFDC recipients (Aid to Families with Dependent Children)
- Number of Food Stamp recipients

History of Abuse

To get this information it is best to ask teens anonymously on a survey. "Have you ever been physically or sexually abused?"

If you cannot survey teens anonymously, the next best source of information is reports of child abuse.

This section was adapted from the "Community Risk and Resource Assessment Training" of *Communities That Care©*, created by Developmental Research and Programs, Inc., DRP is a community risk-focused prevention training system.

Information on *Communities That Care©* training and materials is available from DRP, Inc., 130 Nickerson, Suite 107, Seattle, WA 98109; Phone 800-736-2630; Fax 206-286-1462.

4. *Resiliency focused data collection (protective factors in the adolescent's environment)*

Instead of collecting data solely on the problem behaviors and their risk factors, it is helpful to know the prevalence of the protective factors within the adolescent's environment. (See page 12 for a listing of the protective factors common for teen pregnancy, violence, substance abuse, delinquency, and dropping out.)

Family

What are your family's rules and expectations?
- How do you reward your children for behaving as expected?
- What are the consequences for misbehavior or for behaviors that don't meet expectations?

What expectations do you, as parents, have for your family and for your children individually?

How are decisions made in your family?
- How does your family reach an agreement on family matters?
- How are children's ideas considered?
- Who is the family leader: How does this role change?

How do you, as parents, monitor your children/teenager's activities?

How is anger managed by family members?

How do you, as parents, discourage your children/teenagers from practices that you engage in (such as smoking or drinking)?

How often does your family eat together?

What chores do your children/teenagers have?

How does your family "recreate" together?

What cultural and/or spiritual rituals or traditions are practiced in your family?

How do you encourage and assist your children and teenagers with homework?

How do you show your children/teenager the importance of studying and reading?

How do your monitor TV, videos, and music your children/teenagers have access to?

How often is time set aside for non-TV activities by all family members?

How are you involved in your children/teenager's extra curricular activities?

School

How are the school rules and expectations communicated to the students and parents to insure a clear understanding of their meaning? Are student handbooks or parent conferences used for this purpose?

What is your school policy on drugs, alcohol and weapons? How are these policies enforced?

What opportunities are available for parents and the community to be involved in classroom and school activities?

- How are parents made to feel welcome in the school?
- How are parents and the community informed about school activities?
- How are parents involved in the planning and curriculum review?

How do teachers communicate with each other about students who are experiencing problems?

How and when are parents notified about problems their children or teenagers are having in school?

How active is the parent-teacher organization in your school?

What alternative programs exist for students who are unable to succeed in the traditional classroom?

How does your school access outside resources to help with student problems?

What support systems or services are offered by your school to help decrease student stress or support them when they are experiencing difficulties?

- How many counselors, nurses, and student assistance-type programs exist in your school?

How does the school support peer helping, education, and meditation programs?

How does your school positively recognize students?

What is the average number of students in a regular classroom at one time?

What percentage of teachers have remained in your school the past 5 years?

What grades are the "life skills" taught and which skills are taught?

What extra curricular activities are available to students?

Examples:

- student clubs
- sports
- cultural activities
- youth service activities
- technology and academic enrichment activities

How are students responsible for helping make these activities happen?

How is your school involved in prevention efforts in the community?

Is the school involved in a planning process with the community to address community health (and adolescent health) issues?

To what extent is the school building available for community education and recreation?

Community

Are the following resources available, affordable, and adequate for all families?

- housing
- child care
- job training
- health care
- parenting classes
- cultural activities
- education
- employment

What activities are available for youth after school? Are there numerous recreational, volunteer, and service opportunities for youth?

Examples:

- Arts, music, dance & theater
- Peer helper-type programs
- Youth service opportunities
- Cultural activities
- Mentorship or big brother-type programs
- Native Olympics
- Recreation
- Sports programs
- Teen centers

Who are the people in your community that get things done? (Do people know who to talk to if there is a community or neighborhood concern or a problem?)

Is there full time law enforcement coverage in your community? If not, what support does the community receive to enforce the laws?

How is information shared in your community?

Is there an active parent-teacher type of organization?

Do parents communicate with other parents about child rearing? Is this done formally (i.e. through support groups, classes, etc.) or informally?

How does your community help families experiencing problems?

What are the programs and services for families in need?

How does your community celebrate its cultural traditions?

What opportunities are there for youth-elder activities?

Public Policies and Norms

Adolescent behavior does not happen in isolation of community norms and practices. Part of prevention is examining regulations and policies related to health.

For example, the high correlation between alcohol and injuries (sexual assault, crime, suicide, drowning, and motor vehicle crashes) necessitates a review of local liquor ordinances, licensing procedures, and permits for alcohol-related events. Local ordinances concerning alcohol consumption are a significant backdrop to the use of alcohol and other drugs by adolescents.

What are the public policies related to health behaviors?

What are the community norms (generally accepted behaviors) related to health behaviors? Are they consistent with public policies?

How does the local liquor option law affect the overall health of the community?

If liquor can legally be sold in your community, the following questions maybe helpful in identifying what role alcohol plays in the health of your community.

- What are the consequences to individuals who provide alcohol to minors?
- How does your community decrease availability to alcohol and other drugs?
- Do public agencies sponsor conferences, seminars, or other functions where alcohol is served? Are alcoholic beverages allowed at public activities where children are present?

- What are the liquor licensing ordinances in your community?

  —What is the criteria for evaluating applications for permits to sell alcohol on city property? Are police and health officials part of the review team?

  —Are public hearings required prior to granting a new liquor retail license? Is there a type of "neighborhood impact study" before the granting of a liquor license in a new neighborhood?

  —Are there restrictions in high crime neighborhoods for the number of liquor stores?

- Does your neighborhood/community have a limit to the number of alcohol-related events that may take place in your area?

- What role do alcoholic beverages play in nonprofit fund-raising events? Have soft drink manufactures been approached for sponsorship instead of beer manufacturers? Are supporters encouraged to drink heavily at fund-raising events even though they will be driving home?

If liquor is provided at an event, are provisions made for limiting the amount of alcohol consumed by patrons through:

- Eliminating no host bars;
- Limiting drinks for everyone;
- Restricting the time when the alcohol is served;
- Providing numerous nonalcoholic beverages; and
- Getting "patrons" home who are not safe to drive.

Portions of this survey were developed based on personal communication with Joan Diamond, Municipality of Anchorage, Department of Health and Human Services, Community Health Education.

5. *Community opinion surveys*

A community opinion survey is used to find out what community members feel are the problems facing local teenagers. A *Community Leaders* survey is used to determine what the key community leaders perceive as the problems facing local adolescents. *Teen Focus Groups* are held to gain a youth perspective on the problems facing teens in the community.

Examples of community opinion questions on adolescent issues:

- What are the teen problems that deserve most emphasis?
- What are the causes of most of these problems?
- What can be done to prevent these problems?
- What can be done to assist teens who are experiencing these problems?
- What services, programs, or activities are most needed to address these problems?

Examples of general community health questions:

- In my opinion prevention of __________ should be a high community priority.
- Where do you usually go for health information? (Chose from a list.)
- Where do you go for non-emergency health services? (Chose from a list.)
- What specific health services, health education programs, or activities are most needed in our community?
- How could the existing health services be improved?
- When it comes to ______, I think our community is not as bad as most communities.

Focus Groups

Focus groups are an excellent method to understand the teen's perspective on the problems facing them and their peers. A group setting is less threatening for most teens than individual interviews. The interaction with other teens may produce insights that an interview would not stimulate. Most importantly, perhaps, is that teens will feel that they are a part of the process and the adults in the community are genuinely interested in their views.

Alaska Adolescent Health Advisory Committee

BARNES, Annette Aiken, M.S., is the Vocational Counselor for Fairbanks Alaska Work Programs which provides employment and training services for people who want to get off welfare. She coordinates with the school district's Parenting Teen Program to develop activities that help build self-esteem, encourage self-sufficiency efforts, and facilitate improved career decision making skills. One of Annette's particular areas of interest is regularly soliciting input from employers on how to better prepare applicants for the workforce of today and the future. Annette was born, raised and educated in Fairbanks. She is a life-time member of the N.A.A.C.P. She is also a member of the American Association of University Women, Midnite Sun Chapter of the Lions Club, and the Fairbanks Literacy Consortium. (1995 -)

BOWMAN, J. Dani, Ph.D., M.D., is a pediatrician at the Alaska Native Medical Center and is a board certified member of the American Academy of Pediatricians. She holds a Ph.D. in experimental psychology. Areas of special interest include early cognitive and social development, especially among Alaska Native children, and identification and prevention of child sexual abuse. Dani serves as the chairperson of the Alaska Adolescent Health Advisory Committee (1992 -).

BREWER, Janice, B.A., is coordinator of the Child Care Programs for the Department of Community and Regional Affairs, Division of Community and Rural Development. These programs include implementation and oversight of services to low income parents, grants to child care facilities, and training for caregivers. The services are available in 30 communities within the State. Jan has administered federal and state social services programs in Alaska for over 15 years. She represented the Department on the 1991 Alaska Adolescent Pregnancy and Parenthood Task Force. (1992 -)

BOYD, Sister Arlene J., R.S.M., M.Ed., C.A.E.S., founded and has been director of McAuley Manor, a long-term residential program for "thrown-away" female teens, for eight years. She has a special interest in teens, and has worked with them as teacher, advocate, and care-giver for over 35 years. She was a volunteer at McLaughlin Youth Center for nine years, a member of the 1986 Mayor's Task Force on Homeless and Runaway Youth, and is currently a member of the Child Advocacy Network and the Transitional Housing Strategy Group. Sister Arlene's particular concern is for female teens who are neglected and/or emotionally abused by their parents and who otherwise fall through the cracks in the service system of our State. (1992 - 1994)

BURNSTICK, Don, represented the Alaska Native Health Board on this advisory committee. Don is a Cree Indian who grew up in Canada. As a trainer/educator/actor he has conducted numerous workshops throughout Alaska. Don uses traditional teachings to process the issues of substance abuse, suicide, self-esteem, peer pressure, and sexuality. (1992 - 1994)

CARSON, Wil, is a high school Junior at Colony High School in Palmer. He serves as the Region III representative for the Alaska Association of School Governments, as well as the Southcentral representative for ASTAND, a state student health coalition. Wil was recently elected state president of the Alaska Association of School Governments. Wil is also a member of the Governor's Health & Safety Conferences State Steering Committee. In addition to attending Colony, Wil is concurrently enrolled at the University of Alaska, Mat-Su. (1992 -)

CORKILL, Mike, is a 17-year member of the Alaska State Troopers, currently serving as deputy commander of the Alaska State Troopers "D" Detachment based in Fairbanks. His special areas of interest and expertise are drug enforcement and education, domestic violence intervention and education, and child abuse prevention. Mike is on the board of directors for the Resource Center for Parents and Children and Alaskans for Drug Free Youth. (1992 -)

DOWNS, Irene, B.A., is manager of the Alaska Work Program in Anchorage, which includes the JOBS Program—a holistic approach to assisting families with dependent children to become economically self sufficient. Irene has been active in the employment and training community, serving on the executive committee of the Statewide Vocational/Technical Education Advisory Council for the University of Alaska and as vice-chair of the Anchorage Private Industry Council. Currently she is a member of the Anchorage Training Association and the Alaska Dispute Settlement Association. (1992 -)

EDWARDS, Melanie, is a Siberian Yupik teen from the village of Savoonga on Saint Lawrence Island. In high school she participated in many sports including Native Youth Olympics. In 1991 she was selected as the Bering Straits regional representative for the Alaska Federation of Natives. Melanie attended schools in Tacoma, Washington and at Mount Edgecumbe before graduating from her home school in Savoonga. Currently a sophomore at the University of Alaska Anchorage, she is pursing a degree in

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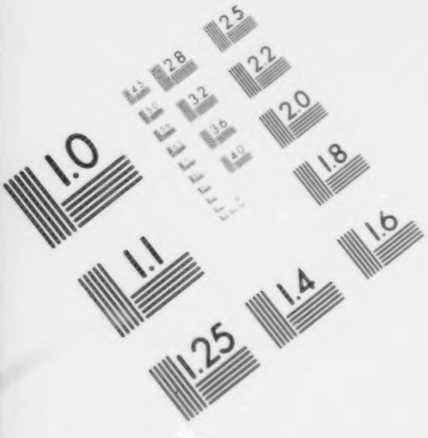

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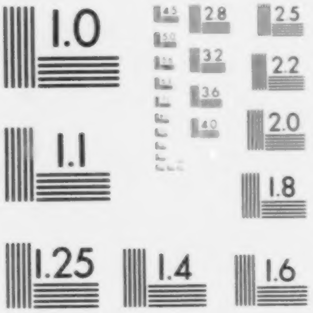
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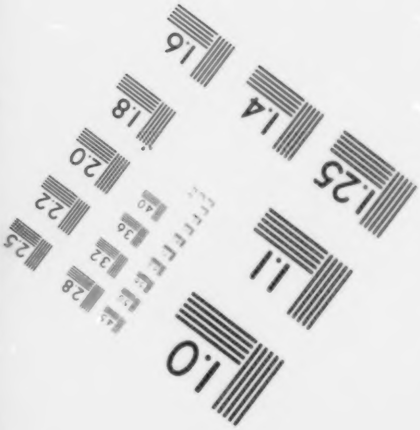
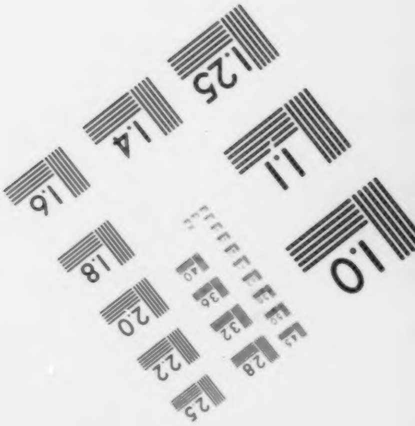

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education with the intention of returning to rural Alaska to teach. (1992 - 1994)

GAMBELL, Cindy, M.P.H., has worked as a community health educator for the Southeast Alaska Regional Health Consortium for ten years on Prince of Wales Island. As a health educator she works with communities and schools in needs assessments, program planning and implementation. She has worked with adolescents as a "Family Live Educator" locally and at statewide conferences. Cindy is a past Craig School Board member and currently serves on Craig's Economic Developoment Committee, Parent-Teacher-Student Association, and the local health corporation. In 1992 she was awarded the Outstanding Leadership Award in Health Promotion and Disease Prevention by the Indian Health Service. (1995 -)

HATTON, Elizabeth A., M.D., is a pediatrician specializing in adolescent medicine. She has been in practice in Anchorage since 1970 and has focused on adolescent problems following a fellowship in adolescent medicine at the University of Washington in 1983. Elizabeth was on the Alaska Governor's Board on Alcohol and Drug Abuse from 1986 to 1990. She is on the medical staffs of Providence, Alaska Regional, and Charter North Hospitals, is a Board Certified member of the American Academy of Pediatrics, and belongs to the Society for Adolescent Medicine. (1992 -)

KOHRING, Sharon, B.S., is the executive director of the Valley Crisis Pregnancy Center in Wasilla. Formerly an elementary school teacher for the Anchorage School District, Ms. Kohring has worked as a sexual abstinence educator in Anchorage, Mat-Su Valley, and other areas of State. Sharon was raised in Alaska and graduated from an Anchorage High School. She is a wife and the mother of three school-age children. (1992 -)

LYMAN, Martha, L.C.S.W., is a licensed clinical social worker for the Yukon-Kuskokwim Health Corporation. As the child and adolescent therapist for the Mental Health Clinic, her service area includes 56 villages plus Bethel. In addition to her outreach work, Martha provides crisis intervention services to teens who have made or threaten to make suicide attempts. She is especially interested in working with adolescent females who have been sexually abused. Martha is a member of the AIDS Task Force in Bethel. (1992 - 1994)

MASTERSON, Jaia, B.A., works for the Yukon Kuskokwim Health Corporation, as the health education supervisor for the Maternal Child Health/Family Planning Center. Jaia supervises an adolescent health program that provides sexuality based education to the rural villages in the YK Delta region. She also provides pregnant and parenting teen case management within the MCH/FP clinical setting. (1992 - 1994)

MEHRKENS, Helen, B.S., C.H.E.S., is the health promotion specialist for the Alaska Department of Education. She is responsible for planning and coordinating the department's health education and promotion-programs with the efforts of school districts and other state and national health related programs. These programs currently include drug-free schools, suicide prevention, HIV/STD prevention, and the Seward Wellness School Health Promotion Conference, as well as Alaska 2000 student performance standards development for "skills for a healthy life." Before starting the health education program, Helen developed state vocational education programs including the statewide student leadership project. She has also worked as a teacher and administrator in Petersburg, Alaska and suburban Minneapolis. (1992 -)

O'BRYAN, Mary, R.N., B.S.N., has been a public health nurse in Alaska since 1974. She is currently the nurse manager of the State of Alaska's Juneau Public Health Center. Mary has been actively involved in adolescent health issues since 1980, working in both Fairbanks and Juneau. She was awarded the Alaska Public Health Association's "Alaska Health Achievement Award" in 1992 in recognition of her work on behalf of Alaska's adolescents. Mary is currently on the advisory board of the school-linked Teen Health Center in Juneau and supervises the public health nursing staff assigned to that clinic. (1992 -)

O'CONNOR, Kimberly, is a junior at Northwest College in Nome, Alaska. She is majoring in Elementary Education with an emphasis in Social Studies. Kimberly is employed by Norton Sound Health Corporation as a Health Educator-Intern. After graduating, she plans on continuing her job with NSHC with the intention of becoming the Director of its Community Health Education Program. She is a member of the Nome Tobacco Alliance and the Lonnie O'Connor Iditarod Basketball Classic. (1995 -)

PAGE, Jay, B.A., is a banker and volunteer in programs for youth. He served on the Mayor's Blue Ribbon Panel on Youth & Violence and is past president of the Youth Crime Prevention Committee. Jay is a board member of Boys & Girls Club of Anchorage and Bootstraps of America. Jay is the statewide board chairman of Junior Achievement of Alaska. A past president and current member of the Anchorage Chamber Crime commission, Page works to change the juvenile justice system. (1992 -)

SCHLEICH, Ley, M.H.A., C.H.E.S., is the former president of the Alaska Health Education Consortium. Ley has worked as the coordinator of health education programs in clinic, school, and community settings throughout the State of Alaska since 1985. Her area of specialty is maternal and child health issues and sexuality education, including teen pregnancy, domestic violence and sexual assault. She is currently nurturing her infant and toddler daughters on a full-time basis. (1992 -)

TERRY, Denny Ann, is a family resource specialist (para-professional) counseling families that include a member with a disability. Terry sponsors "Pathways"—a conference for parents and professionals involved with the disabled and is a founding member of Parents, Inc., a statewide organization for families with a disabled member. She served on the Governor's Council for Children and

Youth, and was recently appointed to the Human Relations Commission. She is interested in a strong prevention format and building parent involvement to strengthen family and community partnerships. Denny has four teenagers (including one who experiences disability) who are now young adults working in Ketchikan. For the past eight years she has worked at Ketchikan High School. (1992 -   )

WHITE, Kim, R.N., C.A.C., is currently the substance abuse treatment program coordinator and case manager for Railbelt Mental Health and Addiction Services, a rural mental health and substance abuse program that serves four communities. Prior to her current position she was the peer counselor program coordinator. Kim has worked closely with adolescent, families, schools, and the four communities she serves doing prevention activities and counseling. Kim co-coordinâted the 1990 Northern Region Governor's Student Health and Safety Conference and received recognition in 1990 from the Alaska Council on the Prevention of Alcohol and Drug Abuse for her prevention efforts. (1992 -   )

WILLIAMS, Cal, is currently working as a Family Counselor at A.F.F.E.C.T. (Agency for Families Enhancement Coordination Teams) in Anchorage, Alaska. He has worked as a community organizer and resource developer for more than thirty years. Cal is the developer of a family building program that has helped hundreds of families with group interaction and growth. Determined to expose and reduce domestic violence, his approach is to work with families for the development of healthy environments. Cal has devoted many hours to volunteer organizations such as the W.I.S.E. project, community councils, N.A.A.C.P., and Correctional Industries. On weekends Cal conducts free acting classes for the youth of the Mountain View and Fairview communities. (1992 -   )

YETT, Gerri, R.N., B.S.N., C.H.E.S., is currently the secretary of the Alaska Health Education Consortium. She has worked as a nurse/health educator in various settings (clinic, school and community) in Alaska since 1981. Gerri's areas of interest and expertise include maternal/child health, sexuality education, pregnancy prevention, STDs/AIDS and reducing barriers to adolescent health care. Her current focus is in promoting lifestyle changes in adolescents to reduce the burden of chronic diseases in the future. Gerri's present position is with the State of Alaska, Diabetes Control Program as a nurse consultant. (1992 -   )

Risk and Protective Factors

A thorough understanding of risk and resiliency (protective) factors is essential for planning successful adolescent health programs. These concepts are discussed in detail on pages 11 - 13.

The risk and protective factors analyzed for this plan exist within the context of the individual, family, school and community. Each area is outlined on the following pages. The risk factor matrix on page B-vi is based on a meta-analysis of adolescent problem behavior by David Hawkins at Developmental Research Programs, Inc.

The common risk and protective factors impacting adolescent problem behavior (substance use, teenage pregnancy, delinquency and school failure) are repeated here as a reference.

Risk Factors

- Poor attachment to family, inattentive parenting, family management problems[2,17]
- Antisocial behaviors (conduct disorders) in grades K-3[2, 17]
- Doing poorly in school in grades 4-6[2, 17]

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- Onset of the problem behavior at an early age (age varies with behavior)[2, 17]
- Low resistance to friends who engage in problem behaviors[2, 17]
- Poverty[2]
- History of abuse (physical or sexual)[11, 13, 16]

Protective Factors

- One good parent bond or other stable, caring adult. High, clear and reasonable expectations of behavior.[2, 3]
- Supportive school atmosphere characterized by a respectful staff, discipline policies that respect student's dignity, services available to help troubled students.[3]
- Opportunities for meaningful contribution to family, school or community.[3]
- Delay of the problem behavior to an older age (age varies with behavior).[2]
- Having a resilient temperament and a positive social orientation.[12, 17]

Please note: the reader should not infer a correlation or cause/effect relationship between any of the factors based on how the information is presented on these pages. The factors are presented in a columnar format simply as a formatting style.

Risk and Protective Factors

The following factors are common to two or more adolescent problem behavior areas (subtance abuse, delinquency, school drop out, teen pregnancy and casual sexual behavior). Those factors that apply to only one problem area have been marked with an *.

Factors Within The Family

Risk Factors

- Family management problems; poor discipline -- authoritarian or permissive parenting.[1, 2]
- Inattentive parenting, lack of monitoring.[2, 4, 17]
- Family stability problems[1, 12]
- Family history of alcoholism[1, 2, 3]
- Parental drug use and positive attitudes toward use[1, 2]
- Family history of physical, sexual, and emotional abuse[2, 7]
- Family history of violence, mental illness[2]
- Family history of criminality[1, 2]
- Poverty[2, 12]
- Parents have low amount of education[2]
- Family frequently moves[2*]
- At home alone without an adult[4, 10]

Protective Factors

- Bonds with a caring, supportive parent figure[3]
- High expectations by parent figure; expectations for school success and personal achievement[3, 17]
- Clear and positive standards for behavior; Family rules are clear and consistently enforced. "Authoritative" parenting style is used vs. "permissive" or "authoritarian" (rigid domineering) parenting styles[3]
- Children are acknowledged as valued participants in life and work of the family: involved in chores and family responsibilities; part-time work makes child feel worthy and capable[3, 17]
- Parents have high amount of education[2, 7]
- Spiritual beliefs provide stability and meaning to life[3]

Factors Within The Community

Risk Factors	Protective Factors
· Poverty[2, 3] · Social deprivation[2, 3] · Low neighborhood attachments and knowing neighbors[3] · Transitions and mobility[2] · Urban, high crime, high mobility[2] · Lack of employment opportunities[2]	· Availability of resources: health care, child care, housing, education, job training, employment and recreation, identification of available resources[2, 3, 7] · Provides supportive networks and social bonds; linkages between families, school, agencies and organizations throughout the community[3] · Values youth as a resource, not as a problem[3] · Provide opportunities for youth to make meaningful contributions in the community besides at home and school (youth service-civic participation); give youth sense of purpose and worth[3, 4] · Clear norms and public policies support nonuse among youth; adults examine their own use as role models for youth[3]

Factors Within The School

Risk Factors	Protective Factors
· Negative school climate[3,4] · Availability of drugs[5] · School leaves students behind[2] · Labeling and identifying students as "low ability/high risk"[3] · Anti-social behavior in grades K-3[1,2] · Academic failure in grades 4-6[1,2,5] · Low commitment to schools: low participation, low expectations, school apathy, truancy[1,2,5]	· High expectations of students: encourages goal setting and mastery[2,3] · Caring and supportive atmosphere: staff and students interact, cooperative learning teaching style, and involved parents[4] · Youth participation and involvement: frequent interaction in the learning process; responsibilities are given, and contributions made; youth bond to school and classmates; feel a sense of belonging; existence of peer programs[3] · High achievement and commitment to school[1,2]

Factors Within The Individual

Risk Factors

- Antisocial behavior and hyperactivity in the primary grades[1,2] or in early adolescence.[2]
- Alienation and rebelliousness, lack of social bonding to school[1,2]
- Nonconformity[2]
- Poor perception of life options and future, low expectations[2,5,7]
- Doing poorly in school, grades 4-6[2,17]
- Early first use of drugs and/or heavy use;[1,2,6]
- Early sexual behavior[2]
- Engages in other high risk behavior[2,5]
- Favorable attitudes toward the problem behavior[1]
- Friends who use drugs or show other risk behaviors.[1,2,5]
- Males at greater risk for substance abuse, delinquency and school failure[2]
- Developmental disabilities/delays and learning disorders (includes FAS and FAE)[12]
- Stress/depression[2,8]
- Low church attendance[2,4]
- Overexposure to television[4,7,9]

Protective Factors

- Social competence: responsiveness, flexibility, empathy, caring, communication skills, humor[3]
- Problem solving skills: abstract thinking, flexibility[3]
- Autonomy: sense of independence, identity, self-esteem, self-efficacy, self-discipline, internal locus of control, and impulse control[3,6,12]
- Sense of purpose and future; having goals, expectations, achievements[3,5,7,12]
- Delay of the problem behavior to an older age[2]
- Having a resilient, easy going temperment and a positive social orientation.[12,17]

Risk Factor Matrix

Adolescent Problem Behaviors

Risk Factors	Substance Abuse	Delinquency	Teen Pregnancy	School Drop-Out	Violence
Community					
Availability of Drugs	✓				
Availability of Firearms		✓			✓
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	✓	✓			✓
Media Portrayals of Violence					✓
Transitions and Mobility	✓	✓		✓	
Low Neighborhood Attachment and Community Disorganization	✓	✓			✓
Extreme Economic Deprivation	✓	✓	✓	✓	✓
Family					
Family History of the Problem Behavior	✓	✓	✓	✓	
Family Management Problems	✓	✓	✓	✓	✓
Family Conflict	✓	✓	✓	✓	✓
Favorable Parental Attitudes and Involvement in the Behavior	✓	✓			✓
School					
Early and Persistent Antisocial Behavior	✓	✓	✓	✓	✓
Academic Failure in Elementary Scool	✓	✓	✓	✓	✓
Lack of Commitment to School	✓	✓	✓	✓	
Individual Peer					
Alienation and Rebelliousness	✓	✓		✓	
Friends Who Engage in a Problem Behavior	✓	✓	✓	✓	✓
Favorable Attitudes Toward the Problem Behavior	✓	✓	✓	✓	
Early Initiation of the Problem Behavior	✓	✓	✓	✓	✓
Constitutional Factors	✓	✓			✓

© 1994 Developmental Research and Programs, Inc. The Risk Factor Matrix was adapted from *Communities That Care®*, a community risk-focused prevention training system, developed by Developmental Research and Programs, Inc. (DRP), Seattle, WA. The matrix was developed based on a meta-analysis of adolescent problem behavior research. All rights reserved. No reproduction or transmission in any form or by any means, electronic or mechanical including photocopying and recording, for any purpose without the express written permission of DRP, Inc. is allowed.

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Healthy Alaskans 2000: Adolescent Health Objectives

Healthy Alaskans 2000 is the state disease prevention and health promotion plan based on national public health objectives for the year 2000. ***Healthy People 2000***, the national document, contains some 300 major health objectives for the nation. It not only sets goals for reducing mortality rates due to disease, but to a much greater extent, focuses on the underlying, preventable causes of disease. The three major goals of *Healthy Alaskans 2000* are to:

- increase the span of healthy life for Alaskans;
- reduce health disparities among Alaskans; and
- achieve access to preventive services for all Alaskans.

Healthy Alaskans 2000 represents the work of over 450 Alaskans who participated in the "1992 Health Summit." They have worked with the Department of Health and Social Services to develop the priority health status areas contained in the report. It represents Alaska's plan to assess the health status of Alaskans and provide a framework for action in addressing these problems throughout this decade.

Alaska has the second youngest population in the U. S. and one of the highest rates of premature, and often preventable death. Many indicators are a reflection of widespread alcohol abuse, and the lack of access to primary care and preventive services. Many Alaskan communities have few, if any, health care providers. While financial means is often a threshold issue for obtaining health care, Alaska's geography and distances create still further obstacles.

The ***Healthy Alaskans 2000*** health objectives for adolescents have been included in this plan as a reference. These objectives provided a benchmark from which a comprehensive, statewide adolescent health plan could be developed. The objectives are listed as they appear in the ***Healthy Alaskans 2000*** document. For example, our indicator "substance use" is listed as "tobacco" and "alcohol and other drugs."

Healthy Alaskans 2000 Adolescent Health Objectives

Physical Activity and Fitness/Nutrition

- Reduce the prevalence of overweight adolescents.
- Reduce the number of adolescents who do not engage in any leisure time activity.
- Increase the number of adolescents who engage in vigorous physical activity.
- Increase proportion of students who participate in daily school physical education during school hours.
- Reduce overweight among adolescents.
- Increase schools that provide education, preferably as part of quality school health education.

Tobacco/Alcohol and Other Drugs

- Reduce the use of smokeless tobacco in adolescents.
- Reduce alcohol-related motor vehicle deaths, ages 15-24.
- Reduce proportion of adolescents who have used alcohol, marijuana, and cocaine.
- Reduce the proportion of high school seniors engaging in recent weekly occasions of heavy drinking of alcoholic beverages.

Family Planning/Sexually Transmitted Diseases/HIV Infection

- Reduce the number of teen pregnancies among females aged 15-19.
- Reduce the number of teen births among females 15-19.
- Reduce the proportion of adolescents who have engaged in sexual intercourse.
- Increase contraception use by sexually active 7-12th graders.
- Increase the proportion of adolescents who have discussed human sexuality with an adult.
- Increase the proportion of schools that have age-appropriate counseling on prevention of HIV and other sexually transmitted diseases.
- Decrease the incidence of gonorrhea among adolescents (15-19).
- Increase the proportion of sexually active, non-monogamous adolescents who have used a condom at last sexual intercourse.
- Increase the proportion of health care providers that treat, diagnose, counsel, and provide partner notification services for HIV infection and bacterial STD's (chlamydia, gonorrhea, and syphilis).
- Increase the proportion of middle and secondary schools that include instruction in STD transmission prevention in the curricula preferably as part of quality school health education.

Mental Health and Mental Disorders

- Decrease the number of adolescent suicides (age 15-19).

- Decrease the prevalence of mental disorders among children and adolescents.

Intentional Injuries

- Reduce the rate of alleged maltreatment of children.

Educational and Community-Based Programs

- Increase the high school graduation rate.

- Increase proportion of Alaskan schools with planned and sequential quality health education.

These objectives will continue to be refined as the ***Healthy Alaskans 2000*** project moves toward completion in 1994.

The Cost Savings of Prevention

Prevention funding is an important social and economic investment. To the extent that visionary leaders can shift the monetary focus to prevention, we can expect an excellent return on this investment. If funds are not made available for appropriate prevention strategies, the future costs, in dollars and quality of life, will be significant.

Societal Investments			**Societal Savings**
$1.00	on prenatal care	saves	$3.38 in later health costs.[1]
$1.00	on childhood immunizations	saves	$10.00 in later medical costs.[2]
$1.00	on food and nutrition counseling for pregnant women in the Special Supplemental Food Program for Women, Infants, and Children (WIC)	saves	$3.13 in Medicaid costs within sixty days of the infant's birth by preventing low birthweight babies.[2]
$1.00	for quality preschool education, like Head Start	saves	at least $6.00 in later special education, crime, welfare, and other costs.[1]
$3.00	for home visiting services/ child abuse prevention	saves	$6.00 in later child welfare and special education services, medical care, foster care, counseling and housing of juvenile offenders.[7]
$1.00	on Federally funded family planning services to women of all ages	saves	$4.40 in medical care, welfare, and nutrition program costs in the two years following a birth.[8]
$1.00	spent on a child safety seat	saves	$32,000 in later health costs.[3]
$1.00	invested in a poison control center	saves	almost $8.00 in medical costs.[3]

Society Investments			Societal Savings
$1.00	spent on a smoke detector	saves	$65.00 in later medical care, property damage, and other costs.[3]
$1.00	spent on a bike helmet	saves	$30,000 in later health costs.[3]
$1.00	spent on injury prevention	saves	$13.00 in later medical costs.[3]
$1.00	for comprehensive job training, education, and support services through the Job Corps	saves	$1.46 in later crime, lost tax, and other costs.[1]
$1.00	spent on enforcing laws against serving intoxicated patrons of bars and restaurants	saves	$94.00 in later medical care, property, public services, employer and other costs.[5]
$1.00	spent on an intensive sobriety checkpoint program	saves	$8.00 in later medical care, public services, property damage and other costs.[6]

High Cost of Adolescent Injury

- Injury is the leading cause of medical spending for adolescents and young adults.[3]

- Injury treatment is responsible for one fourth of all medical spending in this age group.[3]

- The cost per adolescent or young adult injured totals $23,300. This includes $1,800 in medical cost, $5,500 in future earnings, and $16,000 in quality of life.[3]

- Of adolescents and young adults, motor vehicle crashes account for the largest share of injury cost, followed by firearm injuries, falls, and poisonings.[3]

- Convincing a motorcyclist to wear a helmet saves other people $180 per year.[3]

- The injury price tag for the average gunshot victim is $83,500.[3]

- Costs per child gunshot victim average $3 million per fatality and nearly $390,000 per hospitalized survivor.[3]

- Lifetime medical costs for the average child hospitalized with a nonfatal gunshot wound exceed $27,000. Medical costs for some paralyzed or brain-damaged victims exceed $1 million.[3]

Definitions

Medical Costs include payments for hospital, physician, and allied health services, rehabilitation, prescriptions, nursing home care, home health care, medical equipment, and burial costs as well as insurers' medical care claims processing costs. For violence, this category also includes mental health treatment costs.

Public Program Costs include police, fire, paramedic, ambulance, and helicopter transport costs. For violence, this category also includes social services and victim assistance costs. It excludes mental health services costs. Fact sheets that do not explicitly show public program costs include paramedic, and helicopter transport costs in medical costs.

Future Earnings is the present value of a lifetime's worth of wage and household work that children will be unable to do as adults if they are killed or permanently disabled. The earnings include fringe benefits. This category also includes insurer and employer costs of compensating earnings losses (including their legal expenses). For violence, this category also includes earnings lost by family and friends caring for the injured and the value of school missed when children are temporarily disabled.

Quality of Life places a dollar value on the pain, suffering, and lost quality of life that children and their families experience due to an injury.

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Summary of Adolescent Health Public Hearings

Senator Drue Pearce sponsored two statewide teleconferences on April 20-21, 1994. One of the hearings was designated for *youth only*. Over 140 teenagers and adults from 39 communities participated, by responding to the following questions:

> *What can be done* to prevent alcohol and other drug use, pregnancy, suicide, and violence in Alaskan teens?
>
> *What are the solutions* or ways to combat the underlying causes or risk factors behind these problems?

The Adolescent Health Advisory Committee took into consideration the key points of the testimony as they developed the recommendations on pages 99-143. Seven major themes emerged:

- Support greater education efforts on alcohol and drugs, sex, violence, and suicide;
- Focus on prevention and early intervention for young families and high-risk teens;
- Emphasize peer programs;
- Provide alternative activities for youth;
- Encourage greater awareness and responsibilities for alcohol problems by the community as a whole;
- Collaborate more between agencies; and
- Support greater enforcement of the law when teens commit minor offenses.

The primary themes are illustrated by the following comments from those who participated in the hearings. A full transcript of the public hearings maybe obtained by contacting the Adolescent Health Coordinator, Department of Health and Social Services, Division of Public Health, Section of Maternal, Child and Family Health at (907) 279-4711.

Support greater education efforts on alcohol and drugs, sex, violence and suicide

"Need health classes to have more accurate information. . . . What I heard when I was in treatment for drugs and alcohol rehabilitation was sometimes opposite what was taught in the health class."—Teen

"Need the schools to give grades 7-12 parenting classes that teach the stages through and after pregnancy, what parents have to go through to take care of a child, and the expenses of caring for a child. If teens understand this they will be more cautious about getting pregnant." —Teen

"Need adults to stop preaching."—Teen

"Need more education at an earlier age. . . . Need more than condoms or 'you should not be having sex'."—Teen

"Education does not really strike home because the material comes out of a book."—Teen

"Need drug education to be appealing to kids, not adult materials for kids."—Teen

"Boys and girls should both be educated about abuse and that it is not supposed to happen."—Teen

"Need to learn healthy tools for life."—Teen

"Teens are worried about pregnancy, but are having sex anyway. Need better education in school about sex."—Teen

"Need more sex education in our high school. We feel students need to know how to talk about sex in general with parents or their partners. We feel it needs to be brought up in a more broad perspective and not to teach sex as a taboo thing, that it is natural. . . ." —Teen

"People look at sex education as something that should not be talked about because they think it will make teens go out and have sex. . . . People say they do not need sex education because they are not sexually active. Need more sex education because it is important to know what to do when a situation does arrive and how to handle it." —Teen

"Teens do not know that they can report people for hurting or raping them. This needs to be more heavily addressed in sex education programs at school."—Teen

"Need better drug education and peer support."—Teen

"Need to teach teens the skills necessary to succeed in their adult lives."—Adult

"Need the state to have a uniform drug/alcohol and sex education program in all of the schools starting at the elementary level."—Adult

"Our society needs to differentiate between teaching values and forcing certain moralities. Individual teachers know that if we are not teaching children to think for themselves, then we are not really teaching. Our curriculum needs to include values clarification, self-esteem building, problem-solving, and parenting. These are the real building blocks of education."—Adult

"Training can be one of the most helpful, powerful influences on teens."—Adult

"My grandfather would talk about things we would see in our times, issues that would come up repeatedly. When one problem would come up, you jump on it, than another one would come up and you would jump on that one. Today it is called "crisis intervention" which is waiting for something bad to happen, and then doing something about it. You do not wait until winter time to start drying fish. (We) need to do things ahead of time and in their proper order. The issues that were discussed by the teens are symptomatic of the problem." —Adult

Focus on prevention and early intervention

Support families with young children (especially teen mothers); Provide assistance to teens at-risk before they develop chronic problems

"Abused kids are afraid to speak up about their abuse so they start getting into trouble. They do this to get attention, even though it is not the kind of attention they want. They need to know an appropriate way to deal with anger, and how to prevent taking anger out on people. More discipline is needed at a younger age. We need to send [youth] to jail instead of being released to parents or having plea bargain arrangements or informal probation. We need less 'least restrictive placements' before treatment because the more chances you get, the more trouble you get into, and the harder it is to get help. Need court-ordered family counseling. We need the state to pay more attention to family backgrounds and the fact that children are being abused and that they need counseling."—Teen

"We need to have counselors who have more time for the student's concerns and problems not just their schedules."—Teen

"Need to start counseling children younger in life, when family problems become noticeable, in an attempt to prevent drug use from starting."—Teen

"Need support groups for kids who have had [abuse] experiences, along with school counselors."—Teen

"Need schools to start up various support groups like children of alcoholics."—Teen

"Parent's problems becomes the kid's problems, grades go down, which makes parents more abusive, teachers become disappointed, kids have to fight to get attention. . . . Need counselors to care and be available to kids."—Teen

"Need programs to target the drug users instead of just the people who do not do drugs."—Teen

"We need early intervention and identification of at-risk kids. The teen problems being discussed have the groundwork laid much earlier in elementary and preschool."—Adult

"Substance abuse is often kind of an acting-out behavior, because of the stresses and strains in the family. . . . If a kid is caught using drugs, instead of a 10-day drug and alcohol suspension to the streets, kids need to be suspended into an alternative school site program. During this time they are barred from their home campus and school activities in addition to receiving a thorough drug/alcohol evaluation and participating in a support group."—Adult

"Teens want mediation or time-out support systems when dealing with tough developments at home."—Adult

"Kids get depressed when adults do not notice there is something wrong."—Adult

"Need parenting classes that are culturally appropriate."—Adult

"Need family enhancement programs that strive to keep the families in a healthy state and prevent them from falling into other problems." —Adult

"Needs to be stronger support for early intervention in families." —Adult

"Specific strategies to address adolescent problems must be designed and implemented at the community level. Need facilitators to be available to offer their services to traditional councils, to discuss village strategies, and how to implement them. This is only at the invitation of the village."—Adult

"In working with parents it is important to remember that they need support and education at different times throughout their child's life. As both parent and child develop and change, different life stresses impact the family. Each age and stage brings challenges. Parents often need additional education and support when their children show more independent behavior, particularly around 1-2 years and in the middle school years."—Adult

"The family unit must be strengthened. Parent support, educational opportunities, and parent networking programs can and should be implemented over the long haul. Our families are too isolated from each other and floundering in this isolation."—Adult

"We need family enhancement programs that strive to keep the families in a healthy state and prevent them from falling into other problems."—Adult

"People here do not have extended family to provide support for young parents. Need to have continuing support beyond the age of 16 or 17 as they try to step into the adult life."—Adult

"Need more support for home-visiting types of programs for families at-risk of child abuse and for giving healthy role models."—Adult

Emphasize peer programs

Peer counseling/helping programs, drug-free peer leaders, youth participation in planning programs

"Allowing kids to testify at a public hearing makes them know someone cares."—Teen

"Need more drug prevention training by peers."—Teen

"Need to promote a city-wide student youth council. Need to help keep the adults more in touch with what the kids are thinking and how they are going to react to things."—Teen

"Need to have student role models take a bigger part in the school's education of younger students. There are a lot of [teens] out there who do not abuse drugs and alcohol, but they stay to themselves, rather than play a bigger part in the school, by saying that it is 'OK not to abuse those substances.' "—Teen

"Kids usually talk to their friends first. Kids like the peer helper programs because it gives them someone to talk to other than adults." —Teen

"We need communities to open up and listen to the kids."—Adult

"Need to use the holistic approach and look at the physical, emotional, mental, and spiritual areas. We have young people look at finding solutions in all those areas and from their point of view, which shows them respect and helps them build up self-esteem."—Adult

"Students want an opportunity to discuss these issues. We give them a lot of facts, but there is not often an opportunity for them to be able to discuss them."—Adult

"The most powerful thing that I have seen work is a student-empowerment program. When we look at the challenges facing young people and ask them, ' what is going on, what is working and not working', they really know. If students are given the opportunity, with guidance and free reign, to discuss the problems and to model it [healthy behaviors] for others, that comes across better than anything that any of us can say to kids. A teen that is cross-age teaching, saying the exact same words [as an adult], will get their message across where we would have more difficulty."—Adult

Alternative activities for youth

Need more things to do, outdoor activities, drug-free events, cultural activities, meaningful "service" opportunities and teen centers

"Need more gym time, community support, and community activities."
—Teen

"Nee more things for kids to do."—Teen

"Need more options for things to do after school. Need more extra-curricular activities, which are currently limited to things only a small number of students like to do."—Teen

"Not everyone likes to play sports."—Teen

"Need a teen center. . . . Students sometimes just need to get away from their home environment."—Teen

"Need a drug-free place for teens to gather."—Teen

"Teen centers will not solve youth problems. . . . Teens use boredom as an excuse."—Teen

"Need to promote a big brother/big sister type of program."—Teen

Need to consider service-learning organizations. Need programs to keep kids in school, work-study programs. Need programs of community service."—Teen

"Need schools, cities, and volunteer organizations to work together to get kids to volunteer. Need to get rid of the stigma that community service is only linked to probation."—Teen

"Need family building sessions where families might go in groups to camp or do a weekly activity."—Teen

"Need to provide meaningful community service opportunities for young people, like working with the elderly, cleaning up parks, cleaning graffiti off buildings, and working in the school with younger kids—peer to peer kinds of things. Community service has proven to effectively combat all of the [problems]. Need partnerships of agencies, businesses, and individuals to make opportunities available to young people. Current opportunities are scattered and not very well coordinated."—Adult

"Need educational and job opportunities for young adults, because there is just nothing for them."—Adult

"Need camps for different ages, culture camps, rap groups, healing circles, and dance and drum groups that travel."—Adult

Greater awareness and responsibility for alcohol problems by the community as a whole

"Parents need to clean up their act or drink somewhere else. Parents stay drunk for days at a time. Kids are afraid and ashamed of their parents. Sometimes there is not enough food to eat and kids go hungry. Kids experiment with drugs and alcohol if their parents are doing them."—Teen

"Need community leaders and tribal members to get together and provide different ways to cope with alcoholism. . . . Need organized tribal government to provide laws to deal with violence, delinquency and alcohol and drug abuse."—Teen

"Adults are using alcohol and drugs in front of teens. Need to ban tobacco, drugs, and alcohol. Need stronger penalties for people who use drugs and alcohol."—Teen

"Need to ban imports of alcohol and stop selling to minors."—Teen

"Parents and school administrators saw the alcohol and violence problems getting out of hand; they formed a parent advisory group. A couple of times a year meetings are held. Sometimes panel discussions take place between students, parents, and community leaders. As a result of one of these discussions parents agreed to sponsor, on a regular basis, nonalcoholic, movie-style parties."—Teen

"Need to educate the communities. There is a high level of denial of the severity of the problems and difficulties teens are facing. . . . Healing an individual does not last when the youth is returned to a family or community that denies there is a serious problem. Need to help communities design solutions, based on resilience."—Adult

"Need to remember that people in communities need to not 'shrug our shoulders and just avoid the problems'. Need to open up our hearts and take the time to spend with the children."—Adult

"The state has neglected to set standards for adult abuse of drugs and alcohol. If it is acceptable for adults to be drunk in public, to get off when they commit acts of violence when alcohol is involved, we cannot expect it to be different for our youth. . . . Need probation to take alcohol and these other problems more seriously than they do, and quit slapping hands the first time. . . . Need truth in sentencing."
—Adult

Collaboration between agencies, greater coordination of efforts

"There is no framework for collaboration with treatment providers, agencies, or individuals. There are several agencies that are very good and that we refer to but that is on a really informal, private basis." —Adult

"Need the private and public sector to be walking hand-in-hand if we are going to meet children's needs."—Adult

"Need school district, treatment programs and DFYS to work via an integrated approach. Need to make sure referrals are made, that other agencies have the capacity, capability, and willingness to meet with kids and parents."—Adult
"Need communities to start coordinating in a pro-active way. Need to look at solutions that mean the agencies go beyond turf issues and work together."—Adult

"Need schools and communities to work together actively. Need teachers to be a part of the community, however they work that out in the particular community. Teachers need to visit homes and talk to parents. Schools need to coordinate their educational activities with those of the local or regional health providers."—Adult

"Need the state to have its focus on local programs, assessment of issues, and collaboration with local resources. When things are kept locally there is an opportunity for kids and parents to be involved in developing a program and ownership for those programs."—Adult

Support greater enforcement of the law when teens commit minor offenses

"Need to allow foster homes to dole out better discipline instead of foster parents having their hands tied behind their backs."—Teen

"Need laws to be stricter and more thorough for teens under the influence."—Teen

"Need to enforce the consequences of drug use. People [teens] do not receive punishment for DWI's and other offenses. . . . Students will get pulled over after going to a party and because an officer does not want to fill out the paperwork he just lets the teen go home. Ninety percent [of the teens] will not go home, they will go to another party and crash [stay over night] there."—Teen

"The state of Alaska needs to enforce the laws against consumption of alcohol by minors. The state needs to stop saying it is a social problem and start taking action against the minor and the family. Minors see there are no consequences for their actions and continue to abuse." —Adult

"Social workers and juvenile probation officers are highly trained and dedicated, but they need more funding so they can do their jobs. Need intervention instead of leaving children to their own direction until a serious altercation happens or they are seriously addicted. Need to hold young people and their families accountable for their actions. Need to intervene before there is a serious problem. Need to help children learn from their mistakes instead of overlooking those mistakes. Need to stop letting them think their actions are acceptable to the community and the state."—Adult

"Need to give the agencies clear definitive guidelines as to who is going to handle what."—Adult

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Glossary

AFDC: Aid to Families With Dependent Children

AIDS: Acquired immunodeficiency syndrome

ATODA: Alcohol, Tobacco and Other Drug Abuse.

Abstinence: Not doing something. There are many forms of abstinence including, not having sexual intercourse, not using alcohol or other drugs.

Acquaintance or Date Rape: Unwanted, forced sexual intercourse that happens in the context of a date, friendship, or casual relationship.

Adequate Prenatal Care: Adequate prenatal care must begin in the first trimester (within the first 13 weeks of the pregnancy). According to the Kessner Index a woman should have at least 9 more visits by the end of her pregnancy.

Adjudicate: To settle something through the court system; to take to trial to determine guilt or innocence.

Adolescence: The period between childhood and adulthood that begins with the pubescent growth spurt and ends with social maturity. Defined in this report as ages 10-19.

Aggravated Assault: To recklessly or intentionally cause serious physical injury by means of a dangerous instrument (weapon).

Aid to Families With Dependent Children (AFDC): A program, established by the Social Security Act of 1935, providing cash payments to needy children (and their caretakers) who lack support because at least one parent is dead, disabled, continually absent from the home, or unemployed. Eligible families must meet income and resource criteria specified by the State.

Alcohol Poisoning: Alcohol toxicity sufficient to cause permanent injury or death; defined by effect; quantities vary based on individual, stomach contents, etc.

Alcohol Psychosis: Mental disorder caused by excessive use of alcohol.

Allegation: A claim or charge that a crime has been committed.

Allergies: Conditions in which body tissues react to some irritating substance, such as cats, dust, plant pollen, or certain foods.

Alternative School Programs: Educational programs that are different from the conventional school setting as a means of meeting student needs.

Anorexia Nervosa: A mental disorder occurring mostly in females, usually beginning in adolescence. It is characterized by refusal to maintain a normal minimal body weight, an intense fear of becoming overweight regardless of how much weight is lost. A body image is created of feeling fat even when extremely thin.

Assault: Unlawful intentional inflicting, or attempted inflicting, of injury upon another person (may be with or without a deadly or dangerous weapon).

At Risk: A phrase used to describe an adolescent in an environment, having an existing health problem, or exhibiting behavior, that may result in a poor health outcome.

Authoritative Parenting: A combination of open communication, and give-and-take between parent and adolescent, in an environment of consistent support and firm enforcement of unambiguous rules. Authoritative parents are not authoritarian (harsh, rigid, domineering), overindulgent, indifferent, or rejecting.

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Autopsy: Examining the body after death to determine cause of death.

Blood Alcohol Level: Legal definition of intoxication; varies by state; represents percentage of alcohol in blood stream. In Alaska intoxication is defined as an alcohol level in the blood stream that reaches or exceeds .01.

Broad-based (programs): Typically, programs that take a comprehensive rather than narrow approach to addressing a single health program, such as by involving multiple service systems or strategies (e.g., a pregnancy prevention intervention that would involve teaching of life skills and vocational training, as well as provide sexuality education) and possibly by measuring multiple theoretically and practically related outcomes (e.g., avoidance of school dropout as well as pregnancy prevention.)

Bulimia: A mental disorder occurring mostly in females usually beginning in adolescence or early adulthood. It is characterized by episodes of binge eating often followed by abdominal pain, sleep or self-induced vomiting and depression. A person who is "bulimic" is aware that the behavior is not normal and may fear being unable to stop this pattern. The binge eating pattern usually alternates with periods of normal eating or fasting. There is no extreme weight loss in bulimia.

Burglary: Breaking into and entering a house, office, etc. intending to steal something.

Case Management: Case management involves identifying the strengths and needs of a family and or individual, developing a plan of service to address those areas, and performing regular reviews of the progress made toward meeting the needs thereby reducing the risks to healthy outcomes.

Chlamydia: An infection caused by sexually transmitted bacteria. Experts estimate it is the most common STD. Chlamydia usually infects a man's or woman's urethra (the tube leading outside the bladder) or a woman's vagina or reproductive organs. If left untreated, chlamydia may cause painful infections of the reproductive organs which can result in infertility in both men and women. As many as 75% of people with chlamydia have no symptoms.

Chronic: Ongoing or frequently repeated.

Cognitive Defects: Problems with the thinking capacity of the brain.

Cognitive Development: The process of the brain becoming more complex and expanding its thinking capacity.

Cognitive Skills: Specific skills relevant to higher order reasoning and critical thinking, often part of life-skills training programs.

Collaboration: Working together toward a common vision.

Community-based Comprehensive Health Centers: Refers to those centers providing comprehensive health and/or related services that are situated in the adolescents' home community, but are not school-linked.

Comprehensive Program: See Broad-based programs

Comprehensive Services for Adolescents: The elements of comprehensive health and related services for adolescents are not entirely agreed upon. They include, at a minimum, care for acute physical illnesses, general medical examinations in preparation for involvement in athletics, mental health counseling, laboratory tests, reproductive health care, family counseling, prescriptions, advocacy, and coordination of care; the more comprehensive may include educational services, vocational services, legal assistance, recreational opportunities, child care services and parenting education for adolescent parents. Not all services are available at all centers, but a well-functioning comprehensive services center would provide for the coordinated delivery of care both within the center and between the center and outside agencies and providers.

Conduct Disorder: A mental disorder diagnosed on the basis of a pattern of behavior (lasting at least six months) in which a young person violates others' rights as well as age-appropriate social norms and displays at least 3 of 13 specified behavioral symptoms (example: truancy, lying, stealing, fighting.)

Consensus: General agreement based on the principles and purpose of the group.

Contraception: The prevention of pregnancy by any of a variety of means, including periodic abstinence (rhythm method); the use of spermicidal chemicals in jellies or creams; mechanical barriers (e.g., condoms, caps, or diaphragms); prevention of implantation (e.g., intrauterine device); the use of synthetic hormones to control the female reproductive cycle (e.g. the oral contraceptive pill); and sterilization of the male or female partner.

Covariation: The tendency of health problems to occur in the same individual at approximately the same time. The problems may have a single common cause, or one problem may be the cause of another.

Crisis Intervention Services: A not well-defined set of mental health services that can include crisis telephone lines (i.e., hot lines), emergency outpatient services, and a range of crisis-oriented outreach services such as home-based care and mobile crisis teams.

Culture: Implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group.

Decision Making Skills: Skills relevant to the ability to make rational, health-promoting decisions about one's life, often a part of life-skills training interventions.

Delinquent Behavior: Includes two types of acts: 1) acts committed by minors that would be considered crimes if committed by an adult, and 2) status offenses (i.e., acts that are offenses solely because they are committed by a juvenile, such as truancy).

Depression: A mental disorder characterized by prolonged and intense feelings of worthlessness, hopelessness, or irritability and thoughts of death or suicide.

Developmentally Appropriate: Health promotion, prevention, and treatment services and environments designed so they fit the emotional, behavioral/experiential and intellectual levels of the individual who is to benefit from the service. Because of the unique development within even individual adolescents (as well as individuals in other age categories), designing programs so that they are developmentally appropriate is a distinct challenge.

Diabetes: A disease that makes a person's body unable to use or store sugar.

Disability: A term used to denote the presence of one or more functional limitations. A person with a disability has a limited ability or an inability to perform one or more basic (daily) life functions (e.g., walking) at a level considered "typical."

Discrimination: A showing or perceived differences or prejudice toward another person or group of people.

Disorderly Conduct: To disturb another disregarding that the conduct is having an effect on someone else after being informed that the conduct is having that effect. Example: Making unreasonably loud noise, refuse law officers order to disperse.

Dropping Out: Stopping one's education before graduating. Usually refers to leaving high school before graduation. Some people who "drop out" go on to get their GED (a high school equivalency test).

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment program (Medicaid)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program: A state and federally funded, state-administered program under Medicaid that is intended to provide preventive screening exams and follow-up services for illnesses, abnormalities, and treatable conditions to Medicaid-eligible children under age 21.

Eating Disorders: Illnesses that make people starve, overeat, vomit or purge because they think they are fat. Examples: anorexia nervosa, bulimia.

Ectopic Pregnancy: Development of the fetus outside of the uterus, usually in the fallopian tube. Surgery is usually required to terminate the pregnancy.

Educational Deficits: Problems learning (perhaps in only certain learning settings).

Emancipated: Independence; a legal term referring to a teenager's release from parental control.

Emotional Abuse and Maltreatment: Blaming, belittling or rejecting a young person and a lack of concern by the caretaker for the young person's welfare.

Emotionally Disturbed: Not being able to reason and direct emotions in a way normal for one's age. Adolescents who require mental health services are defined as emotionally disturbed.

Emotional Maturity: The attainment of a harmonious relationship between self and environment that allows for constructive work, healthy sexual relationships and generativity.

Empowerment: Empowerment approaches take as a given that individuals, not just professionals, have a set of competencies (knowledge and skills), that these competencies are useful in the design and management of services, and, further, that those competencies can be even more fully developed by giving individuals additional opportunities to control their own lives. Empowerment is sometimes viewed as a health promotion strategy.

Epidemiologist: A person who studies diseases.

Family Counseling: Counseling provided to an entire family rather than solely to an individual.

Family Planning: A range of services intended to help individuals plan when to have children, from counseling concerning the advisability of initiating sexual intercourse to the provision of contraceptive methods.

Fitness: Usually defined as cardiorespiratory or aerobic fitness, but may also include muscle strength, muscle endurance, flexibility, and low body fat.

Freestanding (Comprehensive) Health Services Centers (for Adolescents): Those centers not located within a school, health maintenance organization, hospital, or other facility.

Goals: Long-range aims or targets.

Gonorrhea: An infection caused by sexually transmitted bacteria. If left untreated, gonorrhea can cause reproductive problems, arthritis, dermatitis and heart problems.

HIV: Human immunodeficiency virus (AIDS virus)

Harassment: Continual, unwanted or negative comments or treatment; sexual harassment involves unwanted attention of a sexual nature.

Head Start: A comprehensive early childhood program which originated as part of the War on Poverty in 1964. Children from income eligible families participate in a program which includes parent involvement and education, developmentally appropriate early childhood education, nutrition and health.

Health: Most broadly, a state of optimal physical, mental and social well-being, and not merely the absence of disease and infirmity.

Health Education: Activities aimed at influencing behavior in such a way as it is hoped will assist in the promotion of health and the prevention of disease.

Health Promotion: Most broadly, a philosophy of health or a set of activities that takes as its aim the promotion of health, not just the prevention of disease. Sometimes narrowly defined as the set of prevention efforts aimed at changing individual behavior.

Health Protection: Strategies for health promotion and disease prevention related to environmental or regulatory measures that confer protection on large population groups.

Home-based (Mental Health) Services: Crisis-oriented services, provided on an outreach basis to work intensively with children and families in their homes. Considered the extreme on the dimensions of timeliness, accessibility, and intensity.

Homeless: Anyone who lacks a fixed, regular, and adequate nighttime residence. An individual may be considered "homeless" even if that individual has a primary nighttime residence.

Hyperactivity: A condition of being so physical, busy and active that it is considered excessive and unhealthy.

Incidence: The measure of the number of new cases of a particular disease or condition occurring in a population during a given period of time.

Identity: A feeling of wholeness or self sameness that links past life experiences with present conditions, and a sense of future direction.

Inebriated: Intoxicated, drunk.

Infertility: Not able to have children.

Inhalants: Chemicals that give off fumes or vapor that cause intoxication when breathed in including amyl nitrite, butyl nitrite, solvents, aerosol, nitrous oxide.

Initiation Pattern: A pattern of initial experimenting with different high risk behaviors, especially alcohol and other drugs use.

Initiative: Beginning something.

Inpatient Services: Mental health or alcohol and other drug abuse treatment services provided while the patient lives inside a treatment facility. As opposed to outpatient services in which the person lives at home and goes to a counselor at a clinic, office or treatment facility.

Intentional Injury or Death: Hurting or killing someone or ones self on purpose. Intentional injuries may include assaults, mugging rape or suicide attempts. Intentional deaths include murder, homicide, and suicide (see unintentional injuries).

Inter-Personal Skills: Skills used to deal with other people. (Example: How to cope with peer pressure, how to make friends.)

Intervention: To intervene (interrupt) a course of action in some way. (examples: provide counseling services to people with problems, confront someone about their drug usage.)

Intoxication: The affect of alcohol or other drugs to the point where physical and mental control is diminished; drunk.

Isolation/Alienation: Being alone or feeling alone to an unhealthy degree, whether by choice or not.

Intra-personal skills: Dealing with one's self and feelings. (Example how to make decisions, or how to cope with disappointment.)

Juvenile Act: An act committed by a juvenile (someone under 18) which if committed by an adult would be a crime.

Life-skills Training; The formal teaching of the requisite skills for surviving, living with others, and succeeding in a complex society. Life-skills training interventions emphasize the teaching of social competence, cognitive skills, and decision making skills.

Maltreatment: Physical, emotional, or educational neglect, or physical, emotional or sexual abuse, most often perpetrated by a family member.

Medicaid: A federally-aided, state-administered program that provides medical assistance for low-income people meeting specific income and family structure requirements.

Mental Injury: Legal term; emotional or psychological impact of trauma generally documented by psychiatric assessment including psychological testing.

Mental Health Service Provider: Legal term defined by states; can include psychiatrists, psychologists, Master's level counselors, Bachelor's level counselors, social workers, paraprofessionals, case managers, outreach workers, etc.

Mental Injury: Mental stress caused by a caretaker that causes an adverse effect on the health, feeling, appearance or reputation of a young person.

Mentoring: The practice of acting over time as a guide, tutor or coach, and sometimes as an advocate for another, typically not biologically related, person.

Methodology: The method used to study something.

Minor Offenses: Federal Bureau of Investigation Part II offenses, which include drug abuse violations, weapons violations, assaults without weapons, disorderly conduct, involvement with stolen property (from minor value theft cases), driving under the influence of alcohol or other drugs, and status offenses.

Miscarriage: Also called spontaneous abortion; when an embryo or fetus is expelled from the uterus on its own (usually occurs between 12th and 28th weeks of pregnancy).

Morbidity: The rate of, or incidence of disease in a population. *Also see New Morbidities.*

Mortality: The rate of, or incidence of death in a population.

Multi-Handicapped: Having more than one condition that causes a disadvantage in normal functioning, such as a physical disability or mental retardation.

Needs Assessment: A systematic approach to identifying needs for services in a particular geographic region or population that provides an important context for program planning and evaluation activities. Originally developed to improve planning, resource allocation and program planning.

Neglect: Failure of a caretaker to provide for a young person's basic needs such as food, clothing, shelter, Medicare care and supervision.

Nerve/Sensory: Having to do with the impulse-carrying capacity of the body that allows one to sense things.

New Morbidities: Illnesses and conditions caused by social and behavioral (rather than organismic) factors (e.g., outcomes of sex, drugs, and violence).

Nosologist: A doctor who specializes in the classification of diseases.

Obesity: An excess of body fat. To be considered obese is to have a body fat content greater than 25% for males and 30% for females.

Objectives: Short-term results. Objectives state who will experience what change or benefit how much how soon.

One-stop Shopping: A setting for health care services that delivers an entire set of comprehensive health (and, often, related) services. Currently an ideal rather than an actuality.

Orthopedically Impaired: Problems with bones, joints, or the skeleton.

Overweight: An excess of body fat approximately 120% of desirable body weight.

Paradigm: A model or way of doing things.

Perceptual Problems: Not being able to pick up stimuli from one's environment.

Physical Abuse: Physical violence, including kicking, biting, hitting with one's fist, beating, burning or scalding, and using a weapon.

Physiological: Having to do with organs, tissues, and cells, and the physical and chemical phenomena related to organs, tissues, and cells.

PID: Pelvic inflammatory disease is an infection of a woman's pelvic and sex organs: her uterus, fallopian tubes and ovaries. A woman may get PID from an untreated sexually transmitted disease. PID can also cause painful scarring of the pelvic organs, which may require surgery or a hysterectomy.

Polydrug Use: The use of more than one drug at a time. Being addicted to more than one drug. Most typical polydrug use include: alcohol-marijuana, marijuana-cocaine, cocaine-depressants.

Possession and Consumption of Alcohol: Legal term, defined by states re: having alcohol in your possession and consuming it.

Prenatal: The period before birth. Prenatal health care services are provided to pregnant women with the intention of improving pregnancy outcome.

Prenatal Care: Medical services related to fetal, infant, and maternal health, delivered from time of conception of labor.

Prevalence: A measure of the number of individuals in a given population who have a specific disease or other condition at a designated time (or during a particular period). The degree to which something is prevalent.

Prevention: Anticipating problems and addressing the problems before the signs and symptoms occur. Effective prevention programs are comprehensive in approach, using many strategies addressing all aspects of the community to reduce ATODA. Levels of prevention are:
Primary: before the onset of the problem.
Secondary: intervention following the onset of the problem.
Tertiary: treatment of the problem to prevent its worsening.

Proactive: Efforts that attempt to promote health and prevent the occurrence of health problems by changing environments rather than merely attempting to change individual behavior through didactic attempts at persuasion.

Problem Behavior (in adolescence): Those behaviors that have been deemed socially unacceptable or that lead to poor health outcomes (e.g., unprotected sexual intercourse, substance abuse).

Protective Factors: See resiliency factors.
Psychiatric Disorders: Those disorders listed and defined in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Psychosocial Development: The process of a person's mind and emotions and interactions with other people become increasingly more complex and advanced.

Puberty: Point in development culminating in the attainment of sexual maturity - for girls: menarche, for boys: presence of spermatozoa.

Race: Races can be distinguished by usually inherited physical and physiological characteristics without regard to language or culture.

Rape: Forcing sexual intercourse.

Reckless Conduct: To create substantial risk of serious physical injury.

Regular Physical Exercise: At least 20 minutes of exercise a day, three times a week.

Remediation: To cure, heal or treat someone or something.

Resiliency (or protective) factors: Those factors that increase an individual's and community resistance to developing such problems as drug/alcohol use, teen pregnancy, violence, delinquency, school dropout. Resiliency factors may be found within the individual, family, school or community. When in place protective/ resiliency factors reduce the impact of risk factors or change the way a person responds to risks. (see risk factors)

Risk Factor: Those factors that increase an individual's and a community's vulnerability to developing such problems as drug/alcohol use, teen pregnancy, violence, delinquency, school dropout. A concept used to predict the probability of a behavior to occur. Risk factors may be intrinsic (with the individual) or in place with the family, community or environment. The greater the number of risk factors in an adolescent's life the more likely problem behaviors will occur. (see resiliency factors)

Risk-Taking Behavior: An activity that may involve a risk to one's health. For adolescents especially, risk-taking generally carries a negative connotation, but some risk-taking is essential to the further development of competence, and thus some risk-taking can have positive health and other benefits.

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Runaway: A runaway minor is a person under 18 years of age who:
1. is habitually absent from home; 2. refuses to accept available care; 3. has no parent, guardian, custodian, or relative able or willing to provide care; or 4. has been physically abandoned by both parents, the surviving parent, or one parent if the other parent's rights and responsibilities have been terminated or voluntarily relinquished.

Rural: Villages or other communities that are a long distance from highly-populated areas.

STD: Sexually transmitted diseases

Safer Sex Practices: Sexual practices designed to avoid actual and potential transmission of HIV infection and other sexually transmitted diseases (e.g., avoiding exchange of body fluids, use of condoms).

School-Linked Health Centers: Refers to any school health center for students (and sometimes the family members of students and/or school dropouts) that provides a wide range of medical and counseling services and is located on or near school grounds and is associated with the school.

Services for Mentally Retarded: Identification, evaluation, education, case management support (counseling) services to client, family, care-givers, etc. including respite care.

Serious Offenses: Federal Bureau of Investigation Part I offenses, which include specified violent offenses (i.e., murder and non negligent manslaughter, forcible rape, robbery, and aggravated assault) and specified property offenses (i.e., burglary, larceny-theft and arson).

Severely Emotionally Disturbed (SED) Adolescents: A severely emotionally disturbed adolescent is one who exhibits severe and persistent disorders (not acute problems) which require intensive mental health services. An SED adolescent is typically under the age of 18 who:

1. Exhibits severe behavioral, emotional, or social disabilities that disrupt the adolescent's academic and developmental progress, family and/or interpersonal relationships, often to the point that the adolescent is at risk for out-of-home placement.

2. Has disabilities that cannot be attributed solely to intellectual, physical. or sensory deficits; and

3. Frequently requires intensive, well coordinated treatment delivered by an interdisciplinary team involving the family, courts, education, mental health and other family services agencies.

Severely Mentally Ill Adolescents: Severely mentally ill adolescents are part of the overall group of severely emotionally disturbed adolescents. These youth must be diagnosed as having a schizophrenic, major affective, or paranoid disorder, or must be judged likely to exhibit these disorders in the future.

Sexual Abuse: Any contact of a sexual nature that is a result of being forced or tricked; "contact" can include touch, sight, hearing.

Sexually Active: As typically used in the literature, sexually active denotes ever having had sexual intercourse (as opposed to currently being sexually active).

Sexuality: Reflects a composite of: anatomical condition, sex-role to which one ascribes, and expression of that gender identity with the society.

Shoplifting: Stealing goods, merchandise from a store.

Short Attention Span: Not being adequately able to mentally focus on something.

Sliding Fee Scale: A system that has people pay for a service based on some set of criteria, such as their income or other measure of ability to pay.

Somatic: Having to do with the body.

Special Educational Services: Services provided to students with a variety of physical and emotional special education needs; such as learning disabilities, handicapped or academic.

Spectrum: A continuous range of something, such as opinions or light.

Stillbirth: (Stillborn) The birth of a dead fetus.

Status Offenses: Acts that are illegal solely because they are committed by a juvenile.

Stereotyping: Having a fixed notion about something or someone or a group of people, without allowing for individual differences or critically thinking about it.

Strategy: A plan of action that looks at strengths, barriers and resources in relation to achieving a specific objective.

Substance: Term used for alcohol, tobacco, and illicit drugs.

Substance Use: The use of alcohol, tobacco or other drugs.

Substantiated Report of Harm: Allegations supported by fact. A report of allegation that has been investigated and found to be true.

Supplemental Special Educational Programs: A set of special educational services required by the state or federal government.

Thrownaway: A child or adolescent who has been told to leave the household, has been abandoned or deserted, or who has run away and no effort has been made to recover him or her.

Trespassing: To go on another person's land or property without their permission.

Truant: Staying away from school without permission.

Unintentional Injury or Death: Hurting or killing someone or oneself not on purpose. Most common causes of adolescent unintentional injuries and fatalities include: automobile, ATV/ 4-wheeler crashes, sports injuries, falls, drowning (see intentional injuries).

Urban: Having to do with a city or highly populated area such as Anchorage, Fairbanks or Juneau.

Values: Ideals, goals, or standards which direct one's behavior and subsequently judges that behavior as good/bad, right/wrong.

WIC: Women Infants and Children - a nutrition program for low income pregnant or nursing mothers and their children from birth to age six.

Wrap Around Services: A term used to denote a philosophy or practice of flexibly providing and funding mental health services that are designed to meet the unique needs of a particular adolescent, rather than (or in addition to) providing specified funding for particular settings or types of services (e.g., hospitals). The service package is developed by the child or adolescent's case manager and is purchased from vendors; when a service for a given child or adolescent is not available from an existing organization, funds are used to develop the service (e.g., flying in a consultant to treat a patient with schizophrenia rather than moving the patient to a hospital in another State).

Youth Probation Referral: A police report of criminal activity by youth. An allegation (charge or accusation) that a juvenile act (crime) has been committed by a minor (someone under 18). The term "arrest" can not be technically applied to someone under 18.

Youth Probation (System): Youth probation is part of the youth correction section of the Division of Family and Youth Services. Youth Probation employs probation officers who do preliminary investigations of juvenile crime activities, make recommendations to the court for disposition and supervises youth on probation.

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